Humana Health Benefit Plan of Louisiana, Inc.'s
Proposal Prepared for the State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing
RFP for Louisiana Medicaid Managed Care Organizations

RFP Number: #3000017417

2.5 Business Proposal
2.6 Technical Proposal

REDACTED COPY

Humana
Healthy Horizons™
in Louisiana

1.8 Cover Sheet

Confidential Information, Trade Secrets, and Proprietary Information

The data contained in pages [see table below] of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions.

RFP Section Number	RFP Section Description	Page(s)
Business Proposal		
2.4.1	Cover Letter	4(E)
2.5.1	Mandatory Qualifications	1
2.5.6.2	Exhibit A	1006(E)
2.5.6.3	Exhibit D	1013(E); 1017(E); 1036(E); 1038(E); 1040(E); 1042(E); 1044(E); 1046(E); 1048(E); 1050(E); 1052(E); 1054(E); 1056(E); 1058(E); 1060(E); 1062(E); 1064(E); 1066(E); 1068(E); 1070(E); 1072(E); 1077(E)-1251(E)
Technical Proposal		
2.6.2	Proposer Organization and Experience	8-24; 25-30; 31-39
2.6.3	Enrollee Value-Added Benefits	40-53
2.6.4	Population Health	56-66
2.6.5	Health Equity	67-78
2.6.6	Care Management	80; 82-90; 93
2.6.7	Case Scenarios	94-138
2.6.8	Network Management	140-144; 146-148
2.6.9	Provider Support	149-152; 154-158
2.6.10	Utilization Management	161-167; 173; 175
2.6.11	Quality	176-188; 190
2.6.12	Value-Based Payment	191-200
2.6.13	Claims Management and Systems and Technical Requirement	208 1281(E)-1296(E)
2.6.14	Program Integrity	211
2.6.15	Physical and Specialized Behavioral Health Integration Requirements	221; 223; 227; 229-230
Veteran and Hudson Initiative Program		
4.4	Veteran and Hudson Initiative Program	1297(E) Microsoft Excel/Flash Drive (E)

CERTIFICATION STATEMENT

I, **Joseph M. Ruschell**, being the duly elected and qualified Associate Vice President, Assistant General Counsel & Corporate Secretary of **Humana Health Benefit Plan of Louisiana, Inc. ("Corporation"),** hereby certify that the following resolution was adopted by unanimous written consent of the Board of Directors of the Corporation on April 22, 2021 approving the election of the officer listed below, such election authorizing the officer to execute any and all documents on behalf of the Corporation, including, but not limited to, the Louisiana Medicaid Managed Care Organizations Request for Proposal:

> **RESOLVED,** that each of the persons listed below be, and hereby is, elected to the office of the Corporation set opposite his or her respective name to assume the duties and responsibilities fixed by the By-Laws of the Corporation, and to hold office until (a) the next annual election of the Corporation's officers at the first meeting of the Board of Directors after the 2022 Annual Meeting of Stockholders, or such other date as the Board may determine, or (b) death, resignation, or removal as provided in the By-Laws of the Corporation;
>
> John E. Barger III Senior Vice President, Medicaid President

I further certify that the above resolution is in full force and effect this 18TH day of AUGUST, 2021.

Joseph M. Ruschell
Associate Vice President, Assistant General Counsel & Corporate Secretary

Subscribed and sworn to before me by Joseph M. Ruschell, Associate Vice President, Assistant General Counsel & Corporate Secretary of Humana Health Benefit Plan of Louisiana, Inc. this 18TH day of AUGUST, 2021.

Tracy L. Burch
Notary Public, State-at-Large, KY

My Commission expires: 5-20-2023

Tracy L. Burch
Notary Public, ID No. 623558
State at Large, Kentucky
My Commission Expires on May 20, 2023

Humana sponsors Makin' Groceries Mobile Market, improving access to food and essential resources in rural communities across Acadiana.

Section 2.4

Table of Contents

Humana

Healthy Horizons™ in Louisiana

2.4 Table of Contents

1.8 Cover Sheet ..... i(E)
2.2.1 Board Resolution ..... ii(E)
2.4. Table of Contents ..... 1(E)
2.4.1 Cover Letter ..... 4(E)

2.5 Business Proposal

2.5.1 Mandatory Qualifications 1
2.5.2 Conflict of Interest 3
2.5.3 Moral or Religious Objections 4
2.5.4 Material Subcontractors 5
2.5.4.3-1 Exhibit B DentaQuest (Electronic) ..... 7(E)
2.5.4.3-2 Exhibit B Humana Pharmacy Solutions (Electronic) ..... 22(E)
2.5.4.3-3 Exhibit B Superior Vision (Electronic) ..... 37(E)
2.5.5 Financial Condition (Electronic) ..... 52(E)
Attachment 2.5.5.1-1 HHBPLA 2020 Financial Statements (Electronic) ..... 53(E)
Attachment 2.5.5.1-2 HHBPLA 2019 Financial Statements (Electronic) ..... 107(E)
Attachment 2.5.5.1-3 HHBPLA 2018 Financial Statements (Electronic) ..... 161(E)
Attachment 2.5.5.1-4 HIC 2020 Financial Statements (Electronic) ..... 215(E)
Attachment 2.5.5.1-5 HIC 2019 Financial Statements (Electronic) ..... 275(E)
Attachment 2.5.5.1-6 HIC 2018 Financial Statements (Electronic) ..... 335(E)
Attachment 2.5.5.1-7 Humana Inc. 2020 Financial Statements (Electronic) ..... 395(E)
Attachment 2.5.5.1-8 Humana Inc. 2019 Financial Statements (Electronic) ..... 611(E)
Attachment 2.5.5.1-9 Humana Inc. 2018 Financial Statements (Electronic) ..... 764(E)
2.5.6 Required Forms and Certifications ..... 1004(E)
2.5.6.1 Exhibit C Proposal Compliance Matrix ..... 1005(E)
2.5.6.2 Exhibit A Certification Statement ..... 1006(E)
2.5.6.3 Exhibit D Medicaid Ownership and Disclosure Form (Electronic) ..... 1008(E)
Attachment 2.5.6.3-1 HHBPLA Open or Pending Court Cases (Electronic) ..... 1077(E)
Attachment 2.5.6.3-2 HHBPLA Pending Healthcare Case Documentation (Electronic) .... 1078(E)
Attachment 2.5.6.3-3 HIC Open or Pending Court Cases (Electronic) ..... 1084(E)
Attachment 2.5.6.3-4 HIC Pending Healthcare Case Documentation (Electronic) ..... 1086(E)

2.6 Technical Proposal

2.6.2 Proposer Organization and Experience 6
2.6.2.1 Proposer Organization 6
Attachment 2.6.2.1-1 MMC Contracts Non-Compliance 8
2.6.2.2 Proposed Staff Qualifications and Organizational Structure 25
Attachment 2.6.2.2 -1 Resumes 31
Attachment 2.6.2.2-2 Organizational Chart 39
2.6.3 Enrollee Value-Added Benefits 40
2.6.4 Population Health 55
2.6.5 Health Equity 67
2.6.6 Care Management 79
2.6.7 Case Scenarios 94
2.6.7.1 Case Scenario 94
2.6.7.2 Case Scenario 99
2.6.7.3 Case Scenario 104
2.6.7.4 Case Scenario 109
2.6.7.5 Case Scenario 114
2.6.7.6 Case Scenario 119
2.6.7.7 Case Scenario 124
2.6.7.8 Case Scenario 129
2.6.7.9 Case Scenario 134
2.6.8 Network Management 139
2.6.9 Provider Support 149
2.6.10 Utilization Management 161
2.6.11 Quality 176
Attachment 2.6.11.5 CPG Sample ..... 1252(E)
Attachment 2.6.11.6 Humana's Quality Response Template ..... 1276(E)
Attachment 2.6.11.7-1 NCQA Accreditation FL ..... 1278(E)
Attachment 2.6.11.7-2 NCQA Accreditation KY ..... 1279(E)
Attachment 2.6.11.7-3 NCQA Accreditation SC ..... 1280(E)
2.6.12 Value-Based Payment 191

2.6.13 Claims Management Systems and Technical Requirements 201

Attachment 2.6.13.1 Claims Adjudication Process .....1281(E)

Attachment 2.6.13.2 -1 High Level Systems Architecture .....1282(E)

Attachment 2.6.13.2-2 Key System Architecture .....1283(E)

Attachment 2.6.13.2-3 IT Data Flows .....1290(E)

2.6.14 Program Integrity 211

2.6.15 Physical and Specialized Behavioral Health Integration Requirements 221

4.4 Veteran and Hudson Initiative Programs Participation

4.4 Veteran and Hudson Initiative Response (Electronic) ..... 1297(E)

Microsoft Excel/Flash Drive(E)

Humana provided hand sanitizing stations to TCA-NOLA (community based organization to support their operations during the COVID-19 pandemic.

Section 2.4.1

Cover Letter

Humana

Healthy Horizons™
in Louisiana

Humana
Healthy Horizons™
in Louisiana

September 2, 2021

Ali Bagbey
Louisiana Department of Health
628 N. Fourth Street
Baton Rouge, LA 70802
(225) 219-0206

2.4.1 Cover Letter

Humana is pleased to submit our response to the Louisiana Department of Health's Medicaid RFP No. 3000017417 to provide healthcare services statewide to Medicaid enrollees participating in the Louisiana Medicaid Managed Care Program.

Humana has served Medicaid-eligible populations continuously for more than two decades through programs including Medicaid Managed Care, Medicaid Managed Long-Term Services and Supports, Dual Eligible Integrated Care Demonstrations, Medicare Advantage (MA), and MA Dual Eligible Special Needs Plans. We are eager to extend our existing and long-standing Louisiana presence into Medicaid and look forward to developing a valuable partnership with the Department to the benefit of those it serves.

Per **Section 2.2.1 of the RFP**, we have included a signed copy of the board resolution as **Attachment 2.2.1 Board Resolution**, which certifies that John Barger is an officer of and authorized to sign proposals or contracts on behalf of Humana Health Benefit Plan of Louisiana, Inc.

Please see below for the information requested in **Section 2.4.1 of the RFP**.

2.4.1.1 Location of Administrative Office with Full Time Personnel

Humana Health Benefit Plan of Louisiana, Inc. will have its administrative office with full time personnel in Baton Rouge, Louisiana.

2.4.1.2 Humana's Corporate Principal Office

Name: Humana Health Benefit Plan of Louisiana, Inc.
Address: One Galleria Boulevard, Suite 1200, Metairie, Louisiana 70001
Email: [redacted]
Website URL: Humana.com
Telephone: [redacted]

2.4.1.3 Humana's Corporate Office for Issuing Checks and/or Drafts

Humana Health Benefit Plan of Louisiana, Inc.
P.O. Box 3288
Milwaukee, Wisconsin 53201-3288

2.4.1.4 Other Plan Names

Humana Health Benefit Plan of Louisiana, Inc. will be marketed as Humana Healthy Horizons™ in Louisiana.

2.4.1.5 Ownership Status

Humana Health Benefit Plan of Louisiana, Inc. is a privately held corporation.

Humana Insurance Company, located at 1100 Employers Boulevard, De Pere, Wisconsin 54115, is a privately held corporation, which owns 100% of the outstanding stock of Humana Health Benefit Plan of Louisiana, Inc.

CareNetwork, Inc., located at 500 West Main Street, Louisville, Kentucky 40202, is a privately held corporation, which owns 100% of the outstanding stock of Humana Insurance Company.

Humana Inc., owns 100% of CareNetwork, Inc. and is a publicly traded corporation with its corporate headquarters located at 500 West Main Street, Louisville, Kentucky 40202.

2.4.1.6 Type of Legal Entity

Humana Health Benefit Plan of Louisiana, Inc. is a for profit corporation.

Humana Insurance Company, located at 1100 Employers Boulevard, De Pere, Wisconsin 54115, is a for profit corporation, which owns 100% of the outstanding stock of Humana Health Benefit Plan of Louisiana, Inc.

2.4.1.7 Local Representative Name and Address

Humana Health Benefit Plan of Louisiana, Inc. is located in Louisiana with offices in Metairie and Baton Rouge.

2.4.1.8 Planned Personnel Previously Employed by the State of Louisiana

This is not applicable. None of the planned personnel for Humana Health Benefit Plan of Louisiana, Inc. are current Louisiana state employees nor were employed by the state of Louisiana within the past two years.

2.4.1.9 Tax Identification, LaGov Vendor Number, and Louisiana Department of Revenue Numbers

State Tax Identification Number: 8643017-001
Federal Tax Identification Number: 72-1279235
LaGov Vendor Number: 0310165570
Louisiana Department of Revenue: 8643017-001

2.4.1.10 Involvement in Litigation Related to the Delivery of Medicaid Benefits

Humana Health Benefit Plan of Louisiana has not been involved in any litigation related to the delivery of Medicaid benefits in the last 10 years. Certain corporate affiliates of Humana Health Benefit Plan of Louisiana do deliver Medicaid benefits in other markets and are the subject of a variety of legal actions in the ordinary course of business. Humana Health Benefit Plan of Louisiana and its affiliates cannot predict the outcome of these lawsuits with certainty, but other than as publicly disclosed by Humana Inc. (included in any filings with the Securities and Exchange Commission under EDGAR), there is no recent or pending litigation against Humana Health Benefit Plan of Louisiana, its parent company or any of its affiliates that could reasonably be expected to impair Humana Health Benefit Plan of Louisiana's performance under this contract for managed Medicaid in Louisiana.

John E. Barger, III
Senior Vice President, Medicaid President

Humana Health Benefit Plan of Louisiana, Inc.
One Galleria Boulevard, Suite 1200
Metairie, Louisiana 70001

Kingsley House Head Start program prepares preschool children for successful academic careers by using innovative methods to make learning fun. Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

Section 2.5

Business Proposal

Humana

Healthy Horizons™
in Louisiana

Chris Buchner, Humana Administrative Assistant, hosting a PRIDE National Resource Group (NRG) table in the office. Chris also hosted an Inclusion & Diversity day to encourage participation in our nine NRGs: Access, Caregivers, GenUs, HAPI, Impact, Pride, Salute, Unidos, and Women.

Section 2.5.1

Mandatory Qualifications

Humana

Healthy Horizons™
in Louisiana

2.5.1 2.5.1 Mandatory Qualifications

Humana Health Benefit Plan of Louisiana, Inc., marketed as Humana Healthy Horizons™ in Louisiana, acknowledges and agrees to meet all standards and will comply with all requirements of this section.

2.5.1.1 Meeting the Federal Definition of MCO: Humana Health Benefit Plan of Louisiana, Inc. affirms and certifies that it meets the definition of an MCO, as defined in 42 C.F.R. §438.2.

- Humana Health Benefit Plan of Louisiana, Inc. attests that it meets the advance directives requirements.
- Humana Health Benefit Plan of Louisiana, Inc. attests that it makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity. Please refer to our network submission in **Section 2.10.7** for proof of progress toward and capacity to achieve network adequacy.
- Humana Health Benefit Plan of Louisiana, Inc. attests that it meets the solvency standards of §438.116.

Please see **Figure 2.5.1** for a screenshot of the certification from the Commissioner of Insurance documenting that Humana Health Benefit Plan of Louisiana is duly organized under the laws of Louisiana and authorized to transact business of health and accident in the State.

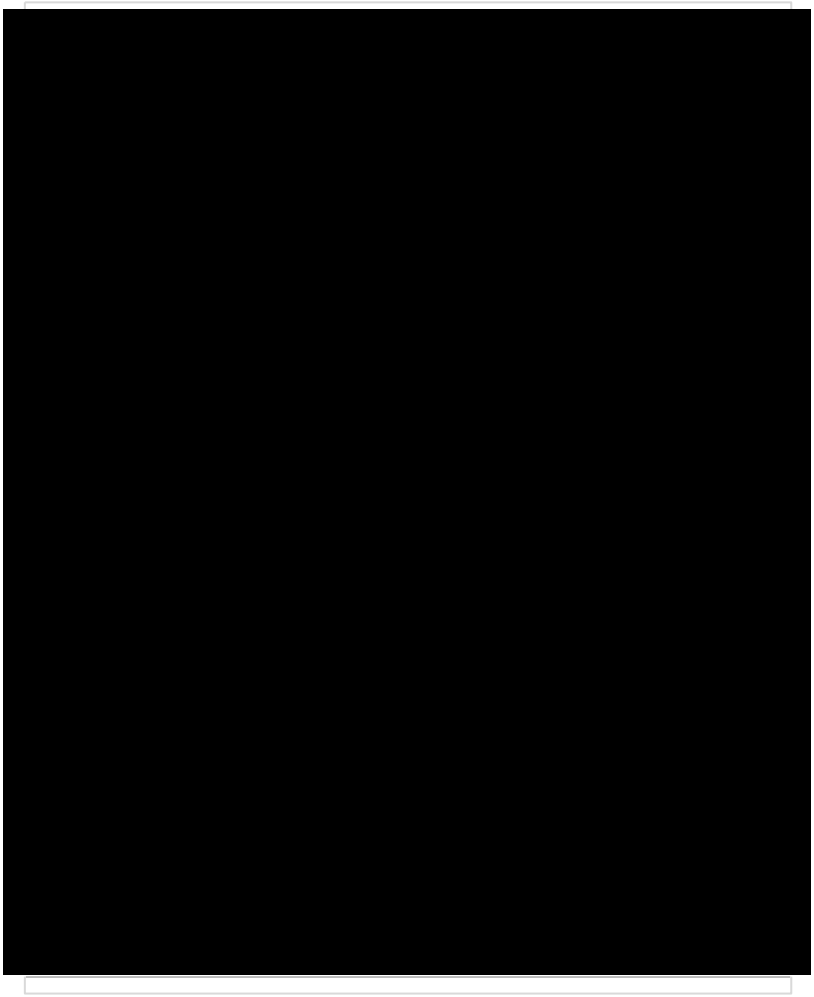

Figure 2.5.1 Certificate from the Commissioner of Insurance

2.5.1.2 Having the Capacity and Willingness to Perform All RFP and Model Contract Functions: Humana Health Benefit Plan of Louisiana, Inc. certifies it has the capacity and willingness to perform all functions in the Louisiana Medicaid RFP and in the Model Contract.

2.5.1.3 Not an Excluded Entity Per 42 C.F.R. §438.808(b): Humana Health Benefit Plan of Louisiana, Inc. certifies it is not an excluded entity as described in 42 C.F.R. §438.808(b).

2.5.1.4 Fulfilling Minimum MCO Experience: Humana certifies that it has a minimum of five years of experience as an MCO for a Medicaid managed care program, depicted in **Table 2.5.1**. Among our earliest Medicaid contracts are Wisconsin in 1994 and Florida in 1997.

Table 2.5.1: Parent Organization MCO Experience

Contract	Enrollees	Populations Served	Current Contract Dates (Initial contract year)
Florida Statewide Medicaid Managed Care Comprehensive Contract including Managed Medical Assistance and Long-Term Care	624,808	TANF; CHIP; ABD; I/DD; foster care children; SMI; Dual-eligible; LTSS-eligible	August 1, 2018-January 1, 2024 (2013)
Illinois Integrated Care Program	5,226	Non Dual Disabled	2014-2017
Illinois Medicare-Medicaid Alignment Initiative	10,029	Dual Eligible	January 1, 2020-December 31, 2022 (2014)
Kentucky Medicaid Managed Care	168,844	TANF; CHIP; ABD, Expansion; Dual-eligible	January 1, 2021 - TBD (2013)
South Carolina Healthy Connections	1,021	TANF; CHIP; ABD; SSI	July 1, 2021 - Ongoing
Virginia Commonwealth Coordinated Care	9,143	ABD; Dual-Eligible	2014-2017
Wisconsin Medicaid Managed Care BadgerCare Plus Medicaid SSI Family Care Partnership	 28,682 10,631 1,324	TANF; CHIP; Expansion SSI; ABD ABD; w/ and w/out Medicare; LTSS	January 1, 2020-Ongoing (2008) January 1, 2020-Ongoing (2008) Regions 3, 11: January 1, 2018-December 31, 2023 Regions 8, 12: January 1, 2019-December 31, 2024 (2010**)
***Membership at the end of the contract period**		****original contract was for Region 8**	

2.5.1.5 Contracts with Populations Equal To or Greater than Louisiana Population: Parent Organization Contracts with Populations Equal to or Greater than Louisiana: Humana was recently awarded a new contract for Medicaid managed care in Ohio (2022 go-live). The Medicaid population of our new contract in Ohio, as well as our contract in Florida, have at least 1.5 million enrollees each.

2.5.1.6 Principal Place of Business: The principal place of business for Humana Health Benefit Plan of Louisiana, Inc. is located in Metairie, Louisiana. Our administrative office will be located in Baton Rouge, Louisiana.

Humana associates volunteer at the Food Bank in Baton Rouge.

Section 2.5.2

Conflict of Interest

Humana

Healthy Horizons™
in Louisiana

2.5.2 2.5.2 Conflict of Interest

Humana Health Benefit Plan of Louisiana, Inc. does not have any interests that will conflict with the performance of services required under this RFP.

2.5.2.1 Certification of No Interests Will Conflict with Performance: Humana Health Benefit Plan of Louisiana, Inc. does not have any financial, legal, contractual, and other business interest that will conflict in any manner or degree with the performance required under the contract. Please refer to **2.5.6.2 Exhibit A - Certification Statement.**

2.5.2.2 Attestation of No Business Interest in LDH's Enrollment Broker Contractor: Humana Health Benefit Plan of Louisiana, Inc. does not have, nor does any of Humana's Material Subcontractors have, any financial, legal, contractual, or other business interest in LDH's Enrollment Broker Contractor, or in such vendors' subcontractors, if any. Please refer to **2.5.6.2 Exhibit A - Certification Statement.**

2.5.2.3 Attestation to Submit Information per LDH Request: Humana Health Benefit Plan of Louisiana, Inc. agrees to submit any additional information requested by LDH that, in LDH's judgment, may be relevant to the Proposer's financial, legal, contractual, or other business interests as they relate to the RFP and contract. Please refer to **2.5.6.2 Exhibit A - Certification Statement.**

2.5.2.4 Certification of No Business Interests Affecting Performance: Humana Health Benefit Plan of Louisiana, Inc. is not aware any financial, legal, contractual, and other business interests of Humana Health Benefit Plan of Louisiana, Inc. or any subcontractor, its affiliates, partners, parent(s), subsidiaries, and related organizations that may affect or impact its performance under the contract.

2.5.2.5 Information Related to RFP and Contract: Humana Health Benefit Plan of Louisiana, Inc. along with the proposed material subcontractors, do not have any other information that may be relevant to financial, legal, contractual, or other business interests as they relate to the RFP and contract.

Kingsley House's Adult Day Care program for seniors: Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

Section 2.5.3

Moral or Religious Objections

Humana

Healthy Horizons™
in Louisiana

2.5.3 2.5.3 Moral or Religious Objections

2.5.3.1 No Moral or Religious Objections to Providing Services Described in the Model Contract: Humana Health Benefit Plan of Louisiana, Inc. has no moral or religious objections to providing any MCO Covered Services described in the **Model Contract, Part 2, Services**.

2.5.3.2 No Moral or Religious Objections to Providing Covered Services: Not Applicable.

Humana Associates volunteer at Second Harvest Food Bank.

Section 2.5.4

Material Subcontractors

Humana

Healthy Horizons™
in Louisiana

2.5.4 2.5.4 Material Subcontractors

Humana Healthy Horizons in Louisiana acknowledges total responsibility for the entire contract and has identified any intended subcontractor relationships and the specific designations of the tasks to be performed.

2.5.4.1 Tasks Performed by Subcontractors: See **Table 2.5.4.2 Material Subcontractors** for information on tasks to be performed by subcontractors.

2.5.4.2 Material Subcontractor Services: Material Subcontractor Services are listed in **Table 2.5.4.2.**

Table 2.5.4.2: Material Subcontractors

Legal Entity Name	Address	Telephone	Services Provided
DentaQuest USA Insurance Company, Inc.	11100 W. Liberty Drive Milwaukee, WI 53224	(262) 834-3736	Dental
Superior Vision Benefit Management, Inc.	939 Elkridge Landing Rd, Suite 200, Linthicum, MD 21090	(800) 243-1401	Vision
FOCUS Health, Inc.	10801 Starkey Road, Suite 104-101, Seminole, FL 33777	(727) 202-4650	Peer Review for Behavioral Health Utilization Management
Harris Rothenberg, International/Humana Wellness	500 West Main St. Louisville, KY 40202	(502) 580-1000	Smoking Cessation and Weight Management Coaching
Whole Health Networks/Tivity	1445 S. Spectrum Blvd., Chandler, AZ 85286	(515) 291.0375	Acupuncture and Massage
Humana Inc.	500 West Main St. Louisville, KY 40202	(502) 580-1000	Legal services, Payment services, Financial services, Information systems, Medical and Product Management, Data Analytics and Wellness Activities
Humana Insurance Company	1100 Employers Blvd. Green Bay, WI 54344	(502) 580-1000	Claims Processing, Customer Service, Front-end Operations, Billing and Enrollment, Utilization Review, and Certain Federal and State Tax Reporting
Humana Pharmacy Solutions, Inc.	515 West Market St. Louisville, KY 40202	(800) 379-0092	Prior Authorizations for J-codes

2.5.4.3 Material Subcontractor Response Template: Per **Section 2.5.4.3, Exhibit B** was completed for material subcontractors providing behavioral health, pharmacy, vision, or transportation services, or a value-added benefit such as dental, and are available electronically.

- Please see **2.5.4.3-1 Exhibit B – DentaQuest**
- Please see **2.5.4.3-2 Exhibit B – Humana Pharmacy Solutions**
- Please see **2.5.4.3-3 Exhibit B – Superior Vision**

2.5.4.4 Signed Exhibit A, Certification Statement: Humana Health Benefit Plan of Louisiana, Inc. has provided a signed **Exhibit A, Certification Statement**.

2.5.4.4.1 Acknowledgement of Legal Obligations: Humana Health Benefit Plan of Louisiana, Inc. acknowledges it will not be relieved of any legal obligations under any contract resulting from this RFP as a result of any contracts with subcontractors; that Humana shall be fully responsible for the subcontractor's performance; and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement will be in writing and will contain terms consistent with all terms and conditions of the contract.

2.5.4.4.2 No Administrative Burden on LDH: Humana Health Benefit Plan of Louisiana, Inc. acknowledges that the use of subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.

2.5.4.4.3 No Contracts for Services without Express Prior Written Approval: Humana Health Benefit Plan of Louisiana, Inc. agrees to not contract with any other party for any of the services provided for therein without the express prior written approval of the Department, unless provided for in the contract.

2.5.4 Material Subcontractors

2.5.4 Exhibit B - DentaQuest
2.5.4 Exhibit B - Humana Pharmacy Solutions
2.5.4 Exhibit B - Superior Vision

(Provided Electronically per Addendum 4: Revision #4)

Exhibit B: Material Subcontractor Response Template

Proposer (MCO) name:
Humana Health Benefit Plan of Louisiana, Inc. (Humana)
Material subcontractor name:
DentaQuest USA Insurance Company, Inc.
Description of the Proposer's role and material subcontractor's role:
While Humana will deliver the majority of services to enrollees and providers under the contract, we have subcontracted certain services to third party vendors. DentaQuest is a full-service dental administrator and offers its clients all elements associated with the oversight of a successful and efficient dental benefit program. DentaQuest is delegated for dental benefit management services.
Explanation of why the Proposer plans to subcontract this service and/or function:
We are committed to providing the highest-quality services to our membership. After a thorough evaluation, we have determined that DentaQuest is best positioned to offer dental benefit management services under the Contract.
A description of the material subcontractor's organizational experience:
As one of the leading dental benefits administrators in the country, DentaQuest is uniquely qualified to serve as Humana's dental benefits administrator. DentaQuest has been administering dental benefits in the government sector since 1993 and has become the largest administrator of government-sponsored dental benefits in the country. We proudly serve: • 3.6 million commercial members • 1.4 million Medicare Advantage members • 1 million marketplace/health exchange/direct-to-consumer members • 25.5 million Medicaid & CHIP members • 1.5 million Medicaid & Medicare Advantage members through our vision product, EyeQuest In addition to being a national dental leader, we also offer local expertise. Having nine years of experience in the state and presently overseeing more than 247,000 lives through Medicaid partnerships with other health plans, we're already familiar with the Louisiana landscape. In 2021 DentaQuest went live with the state contract with LDH for dental carve-out. We regularly work with such stakeholders as the Louisiana Dental Association, the LSU School of Dentistry, the Louisiana Primary Care Association, the Louisiana Oral Health Coalition, and the New Orleans Homeless Alliance Group. With DentaQuest, Humana would get a market-ready, reputable oral health leader that is familiar with navigating Louisiana's regulatory and regional dynamics.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

Subcontractor Oversight

As we do in other Medicaid states, Humana will hold every subcontractor to full compliance with all applicable provisions of the LDH Contract by implementing our standardized selection, monitoring and oversight processes.

Experienced Partners

While Humana has responsibility for and will continue to perform a majority of the functions required by its Contract with LDH, we also understand the importance of choosing and maintaining high-quality subcontractor relationships where functional support is appropriate. Humana is committed to working with partners experienced in serving Medicaid enrollees and delivering services on behalf of our organization, with a focus on the Triple Aim of better health, better care, and lower costs. Prior to contracting, we evaluate our subcontractor candidates carefully, using a strategic and competitive procurement process. This includes internal and external cost analysis to optimize savings opportunities, a sourcing process that includes competitive bidding, contract negotiations, and implementation to ensure every potential partner satisfies all commercial, legal, and compliance standards. Ongoing monitoring and oversight includes all assessments and audits required by both regulation and contract at the time of functional delegation.

All Subcontractors Held to the State's Standards

All applicable legal, regulatory, and contract requirements flow to each subcontractor through the executed agreements specific to performed activities. Humana's robust subcontractor monitoring structure is coordinated across multiple teams at national and local levels. Our well-established delegation policies and procedures ensure consistency across Humana, and we require subcontractors to adhere to a formal Compliance Policy that contains written standards of conduct.

In Louisiana, local executive leadership will oversee the operations and performance of our subcontractors on a continuous basis, applying the LDH Contract requirements and Humana's national policies and procedures to local operations. A dedicated relationship manager for each subcontractor will be responsible for ongoing relationship maintenance and for monitoring subcontractors' performance in accordance with LDH Contract and Humana-specific requirements.

Regular Joint Operating Committee (JOC) meetings will be held with each subcontractor and relevant staff where performance will be assessed, and issues and opportunities will be escalated. Reporting and metrics are also a large part of the monitoring process. We track metrics and supply findings as specified by overseeing agencies, and if a subcontractor's performance does not meet performance standards, an improvement plan is developed and conducted with the subcontractor. All relevant information is submitted to overseeing agencies on their required timelines.

Subcontractor Training and Review Ensure Compliance

Humana will implement a subcontractor attestation process such that subcontractors who deliver services as part of the LDH Contract must certify they have completed all necessary training and fully understand the requirements of the LDH Contract, State and federal laws, and all other applicable requirements. Activities performed by all subcontractors will be under the control and direction of Humana, and our subcontractors can perform no activity without appropriate Humana review, approval, and ongoing formal oversight.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Louisiana Medicaid Addendum, pages 1-2, B.1.
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Louisiana Medicaid Addendum, page 7
3	Specify the effective dates of the subcontract agreement.	Louisiana Medicaid Addendum, page 1, second WHEREAS
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Louisiana Medicaid Addendum, page 2, B.2.
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Louisiana Medicaid Addendum, page 2, B.3.
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Louisiana Medicaid Addendum, page 2, B.4.
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Louisiana Medicaid Addendum, page 2, B.5.
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Louisiana Medicaid Addendum, page 2, B.6.
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Louisiana Medicaid Addendum, page 2, B.7.
10	Identify the population covered by the subcontract.	Louisiana Medicaid Addendum, page 2, B.8.
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Louisiana Medicaid Addendum, page 2, B.9.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Louisiana Medicaid Addendum, page 2, B.10.
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Louisiana Medicaid Addendum, page 2, B.11.
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Louisiana Medicaid Addendum, page 2, B.12.
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Louisiana Medicaid Addendum, page 2, B.13.
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Louisiana Medicaid Addendum, page 2, B.14.
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 3, B.15.
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Louisiana Medicaid Addendum, page 3, B.16.
19	INTENTIONALLY LEFT BLANK	

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Louisiana Medicaid Addendum, page 4, B.18.
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Louisiana Medicaid Addendum, page 4, B.19.
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Louisiana Medicaid Addendum, page 4, B.20
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Louisiana Medicaid Addendum, page 4, B.21.
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Louisiana Medicaid Addendum, page 4, B.22.
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 4, B.23.
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Louisiana Medicaid Addendum, page 4, B.24.
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Louisiana Medicaid Addendum, page 4, B.25.
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Louisiana Medicaid Addendum, page 4, B.26.
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Louisiana Medicaid Addendum, page 4, B.27.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Louisiana Medicaid Addendum, page 4, B.28.
31	Specify that at all times during the term of the subcontract, thesubcontractor shall indemnify and hold LDH harmless from all claims, losses,or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by useof other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Louisiana Medicaid Addendum, page 4-5, B.29.
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Louisiana Medicaid Addendum, page 5, B.30.
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Louisiana Medicaid Addendum, page 5. B.31.
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Louisiana Medicaid Addendum, page 5. B.32.
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Louisiana Medicaid Addendum, page 5. B.33.
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 5. B.34.
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Louisiana Medicaid Addendum, page 6. B.35

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Louisiana Medicaid Addendum, page 6. B.36.
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Louisiana Medicaid Addendum, page 6. B.37.
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Louisiana Medicaid Addendum, page 6. B.38.
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Louisiana Medicaid Addendum, page 6. B.39.
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Louisiana Medicaid Addendum, page 6. B.40.
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Louisiana Medicaid Addendum, page 6. B.41.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Louisiana Medicaid Addendum, page 3. B.16

LOUISIANA MEDICAID ADDENDUM

THIS LOUISIANA MEDICAID ADDENDUM is entered into by and between Humana Health Benefit Plan of Louisiana, Inc. (hereinafter referred to as "**Humana**") and [insert full legal name of Subcontractor], licensed under the laws of the State of Louisiana (hereinafter referred to as "**Subcontractor**"). **Humana** and **Subcontractor** may collectively be referred to as the "**Parties**."

The purpose of this Medicaid Addendum ("Addendum") is to ensure compliance with the Louisiana Department of Health ("LDH") program contract, laws, rules and regulations. This Addendum shall supersede any and all contradictory terms of the [insert title of parent agreement] (the "Agreement") made between the **Parties** to which this Addendum is a part. Any term not otherwise defined herein shall have the meaning given it in the Agreement or the Louisiana Medicaid Managed Care Organization contract between **Humana** and LDH (hereinafter the "LDH Contract").

WITNESSETH

WHEREAS, the **Parties** entered into the Agreement pursuant to which **Subcontractor** agreed to provide certain medical, management or other supporting services to **Humana** or its Members or providers at negotiated rates; and

WHEREAS, the Agreement between the **Parties** was effective as of [insert Agreement Effective Date]; and

WHEREAS, the **Parties** desire to incorporate **Humana's** Medicaid-participating Managed Care Plan, as defined in the LDH Contract, and the following additional related provisions as required by LDH. The following terms and conditions are intended to apply to Subcontractor because of its status as a Material Subcontractor as defined herein, and shall supplement the terms and conditions of the Agreement solely as they relate to Humana's participating Louisiana Medicaid Managed Care Plan.

Notwithstanding any provision of the Agreement or this Addendum, **Humana** maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the LDH Contract. No subcontract will operate to relieve Humana of its legal responsibilities under the LDH Contract.

A. Definitions

1. The definition of "Member" in the Agreement includes persons designated by **Humana** and covered under **Humana**'s Medicaid Managed Care Plan under its LDH Contract.

2. As defined in the LDH Contract, a "Material Subcontract" is any contract or agreement by which Humana procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of any program area or function that relates to the delivery or payment of Medicaid Managed Care Plan covered services including, but not limited to, behavioral health, claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers.

3. A "Material Subcontractor" has a contract with Humana to perform any of the services.

4. "MCO Manual" means a compilation of policies, instructions, and guidelines established by LDH for the administration of the Louisiana Medicaid managed care program.

   Medical providers that are also contracted or delegated to perform functions, services or responsibilities for providing services (e.g., claims processing) under the LDH Contract are deemed to be a Material Subcontractor.

B. Provisions and Obligations

1. **Subcontractor** shall adhere to all requirements in the LDH Contract applicable to subcontractors, a copy of which shall be furnished to **Subcontractor** upon request. The LDH Contract is comprised of and incorporates all provisions of the RFP for award of the MCO services to Humana and any addenda, appendices,

attachments or amendments thereto, as well as any handbooks, the MCO Manual, and other applicable policy guides, manuals and materials.

2. The Agreement and its appendices, including this Addendum and any written delegation agreements contain all the terms and conditions agreed upon by the **Parties**.

3. No modification or change of any provision of the Agreement or this Addendum shall be made unless such modification is incorporated and attached as a written amendment to the Agreement and signed by the **Parties**.

4. No alteration, variation, modification, waiver, extension of the Agreement termination date, or early termination of the Agreement, shall be effective unless reduced to writing, duly executed by the **Parties,** and attached to the original of the Agreement.

5. **Humana** and **Subcontractor** acknowledge that in the event of termination of the LDH Contract between **Humana** and LDH for any of the reasons described in the LDH Contract, **Humana** shall immediately notify LDH in writing and make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to **Humana's** and **Subcontractor's** activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH.

6. **Subcontractor** shall not enter into any subcontract or other agreement for any of the work contemplated under the Agreement without the prior written approval of Humana, and LDH where applicable.

7. If any requirement in the Agreement is determined by LDH to conflict with the LDH Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

8. The **Parties** shall identify within the Agreement the Medicaid population covered by the Agreement.

9. The services provided under the Agreement shall be in accordance with the Louisiana Medicaid State Plan and **Subcontractor** shall provide the services to **Humana** Members/enrollees through the last day that the Agreement is in effect.

10. **Subcontractor** shall be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by **Humana**.

11. The Agreement shall specify the amount, duration, and scope of benefits and services that are provided by **Subcontractor**.

12. If applicable, emergency services shall be coordinated without the requirement of prior authorization of any kind.

13. If **Subcontractor** performs laboratory services, **Subcontractor** shall meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.

14. **Subcontractor** shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to **Humana** enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the LDH Contract). **Humana** enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended, and subject to reasonable charges.

15. All documentation and/or records maintained by **Subcontractor**, and network providers as applicable, related to covered services, charges, operations and agreements under the Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall **Subcontractor** destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

    Subcontractor shall retain, as applicable, enrollee grievance and appeal records in 42C.F.R. §438.416, base data in 42 C.F.R. §438.5(c), MLR reports in 42 C.F.R. §438.8 (k), and the data, information, and documentation specified in 42 C.F.R. §438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

16. **Subcontractor,** for itself and its providers, agrees that they shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General Medicaid Fraud Control Unit ("MFCU"), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of MCOs but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be at no cost to the MFCU, and **Humana**, **Subcontractor** or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. **Humana**, **Subcontractor** and its providers agree that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

    Subcontractor shall comply with the audit and inspection requirements set forth in 42 C.F.R. §438.230(c)(3) and 42 C.F.R. §438.3(k). The state of Louisiana, including LDH, MFCU, Government Accountability Office, and the Louisiana Legislative Auditor ("LLA"), and the federal government, including CMS, Health and Humana Services ("HHS"), the U.S. Office of the Inspector General ("OIG"), and the General Accounting Office, or their designees, have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under the Agreement at any time. This right exists for ten (10) years from the termination of the LDH Contract, or from the date of completion of any audit, whichever is later; provided, however that if any of the entities above determine that there is a reasonable possibility of fraud or similar risk, they may audit, evaluate, and inspect at any time.

    Subcontractor shall make all premises, facilities, equipment, records, systems, program and financial records and service delivery sites open to the state of Louisiana, including LDH, MFCU, Government Accountability Office, and LLA, and the federal government, including CMS, HHS, OIG, and the General Accounting Office, and any of their designees upon request, for the purposes of any audit, evaluation, or inspection. **Subcontractor** shall provide these entities with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with **Subcontractor's** clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the LDH Contract. The rights of access in this provision are not limited to any retention periods, but shall last as long as records are retained. **Subcontractor** shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

17. Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs and LDH requires the same of **Humana** subcontractors. **Subcontractor** shall complete and submit to **Humana** the Medicaid Ownership and Disclosure form as required by LDH. The completed disclosure of ownership will be presented to LDH pursuant to its requirements.

18. **Subcontractor** shall participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by **Humana** and/or LDH or its designee, whether announced or unannounced.

19. **Subcontractor** shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which **Humana** and/or **Subcontractor** practices and/or the standards established by LDH or its designee.

20. **Subcontractor** shall comply with any corrective action plan initiated by **Humana** and/or as required by LDH.

21. **Humana** may assess monetary penalties, sanctions or reductions in payment on **Subcontractor** for failure to comply with the Agreement or credentialing requirements, up to and including Agreement termination. This shall include, but is not limited to **Subcontractor's** failure or refusal to respond to **Humana's** request for information, the request to provide medical records, credentialing information, and like requests at **Humana's** discretion or as a directive by LDH. **Humana** shall impose at a minimum, financial consequences against **Subcontractor** as appropriate.

22. **Subcontractor** shall submit all reports and clinical information to **Humana** for reporting purposes as required by LDH.

23. **Subcontractor** shall safeguard information about **Humana** enrollees according to applicable state and federal laws and regulations and as described in the LDH Contract.

24. The Agreement shall make full disclosure of the method and amount of compensation or other consideration to be received from **Humana** by **Subcontractor**.

25. If **Subcontractor** is delegated for claims processing, **Subcontractor** shall comply with LDH's claims processing requirements as stated in the RFP, LHD Contract, and MCO Manual. These provisions include, but are not limited to, Section 2.11 of the LDH Contract – Provider Reimbursement.

26. **Subcontractor** shall adhere to applicable timely filing guidelines set forth by LDH. These provisions include, but are not limited to, Section 2.18.7 of the LDH Contract.

27. If LDH, its subcontractors or **Humana** discover an error or a conflict with a previously adjudicated encounter claim, **Subcontractor** shall adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or **Humana**, or if circumstances exist that prevent **Subcontractor** from meeting this time frame, by a specified date approved by LDH.

28. **Subcontractor** shall accept the final payment made by **Humana** as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or **Humana** Members or enrollees. "Member" shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

29. Indemnity. Neither **Party** shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The **Parties** shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under the Agreement.

    Subcontractor shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and hold harmless the State of Louisiana and its Authorized Users (as defined in the LDH Contract) from suits, actions, damages and costs of every name and description relating to personal injury and damage to property caused by **Subcontractor**, its agents, employees, partners or subcontractors,

without limitation; provided, however, that **Subcontractor** shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the State.

Hold Harmless: Unless **Subcontractor** is a state agency, **Subcontractor** shall indemnify, defend, protect, and hold harmless LDH and any of its officers, agents, and employees from:

a) Any claims for damages or losses arising from services rendered by **Subcontractor,** or any person, or firm performing or supplying services, materials, or supplies for Subcontractor in connection with the performance of the Agreement;
b) Any claims for damages or losses arising from sanctions due to **Subcontractor's** network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the *Fraud, Waste, and Abuse Prevention* Section of the LDH Contract.
c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by **Subcontractor**, its agents, officers, employees, or subcontractors in the performance of the Agreement;
d) Any claims for damages or losses resulting to any person or firm injured or damaged by **Subcontractor**, its agents, officers, employees, or subcontractors by **Subcontractor's** publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the LDH Contract, or by federal or state regulations or statutes;
e) Any claims for damages or losses arising from failure by **Subcontractor**, its agents, officers, employees, or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;
f) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to **Subcontractor** by Humana;
g) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and
h) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against LDH or their agents, officers, or employees, through the intentional conduct, negligence, or omission of **Subcontractor**, its agents, officers, employees, or subcontractors.

30. **Subcontractor** shall secure all applicable liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect **Humana** and its enrollees as stated in the Agreement. **Subcontractor** shall maintain such insurance coverage upon execution of the Agreement and at all times during the Agreement term and shall furnish **Humana** with written verification of the existence of such coverage.

31. **Subcontractor** shall recognize and abide by all state and federal laws (including Medicaid laws), rules, regulations, guidelines, and subregulatory guidance, applicable to the provision of services. **Subcontractor** and **Humana** stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where **Subcontractor** is based and Louisiana law.

32. The Agreement and this Addendum incorporate by reference all applicable federal and state laws, rules and regulations. Any revisions of such laws, rules, or regulations shall automatically be incorporated into the Agreement as they become effective.

33. **Humana** and **Subcontractor** shall be responsible for resolving any disputes that may arise between the **Parties**, and no dispute shall disrupt or interfere with the provision of services to a **Humana** Member.\

34. **Subcontractor** shall sign the no conflict of interest form in compliance with the requirements of the LDH Contract.

35. To the extent applicable, **Subcontractor** shall adhere to the Quality Assessment Performance Improvement ("QAPI") and Utilization Management ("UM") requirements as stated the LDH Contract. The QAPI and UM requirements shall be included as part of the Agreement.

36. **Subcontractor** shall give **Humana** immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on **Subcontractor's** ability to perform the services in the Agreement.

37. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), **Subcontractor** shall take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

38. **Humana** shall not restrict **Subcontractor** from subcontracting with another MCO or other managed care entity.

39. If **Humana** has entered into an alternative reimbursement arrangement with **Subcontractor**, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by **Humana**.

40. Services to be provided under the Agreement shall be performed entirely within the boundaries of the United States, which includes the fifty (50) states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, **Subcontractor** shall not hire any individual to perform any services under the LDH Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

41. **Subcontractor**, for itself and its providers, hereby assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, "Subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

42. **Humana** shall monitor **Subcontractor's** performance on an ongoing basis and perform a formal review annually. The annual review shall include any performance concerns identified by Humana or LDH. If any deficiencies or areas for improvement are identified, **Subcontractor** shall take corrective action**. Humana** shall provide LDH with a copy of the annual review and any corrective action plans developed as a result and provide ongoing updates to LDH on **Subcontractor's** activities to improve its performance. **Subcontractor** shall provide Humana with updated information and action plans as required to provide ongoing updates to LDH.

43. **Subcontractor** acknowledges and agrees to comply with the provision of R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under the Agreement.

44. **Subcontractor** certifies that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving federal funds or grants from the Federal Government. **Subcontractor** certifies that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689. "Debarment and Suspension," as set forth at 24 CFR Part 24 and "Nonprocurement Debarment and Suspension" set forth at 2 CFR Part 2424. **Subcontractor** has a continuing obligation to disclose any suspension or debarment by any government entity, including but not limited to the General Services Administration ("GSA"). Failure to disclose may constitute grounds for suspension and/or termination of the Agreement and debarment from future state contracts.

45. Claims for services furnished or requested for reimbursement by **Subcontractor** which are not provided for in the Agreement shall not be allowed by **Humana**. In the event it is determined that certain costs which have

been reimbursed to **Subcontractor** pursuant to the Agreement are not allowable, **Humana** shall have the right to set off and withhold said amounts from any amount due **Subcontractor** under the Agreement for costs that are allowable.

46. **Subcontractor** hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for services which are rendered to such enrollees by **Subcontractor** and which are **Humana** covered services.

The **Parties** have the authority necessary to bind all of the entities identified here and have executed this Addendum to be effective as of [insert effective date of Medicaid terms].

ICMVendorName	**HUMANA**
Signature:	**Signature:**
Name: ExternalSignatory	**Name:** InternalSignatory
Title: ExternalSignatoryTitle	**Title:** InternalSignatoryTitle
Date:	**Date:**

Approved as to Form : ICMAgreementCode

Exhibit B: Material Subcontractor Response Template

Proposer (MCO) name:
Humana Health Benefit Plan of Louisiana, Inc. (Humana)
Material subcontractor name:
Humana Pharmacy Solutions, Inc.
Description of the Proposer's role and material subcontractor's role:
Humana is responsible for managing and delivering services to enrollees and providers under the Contract. We will leverage capabilities across our enterprise to deliver an efficient managed care delivery system. Humana Pharmacy Solutions, Inc. is delegated for pharmacy related services such as prior authorizations.
Explanation of why the Proposer plans to subcontract this service and/or function:
To ensure an efficient delivery of services under the Contract, Humana will utilize our affiliate company, Humana Pharmacy Solutions, Inc., to perform services such as managing the Physician Administered Drugs including managing the Prior Authorization List (PAL) and completing coverage determinations.
A description of the material subcontractor's organizational experience:
Humana Pharmacy Solutions®, Inc. (HPS), located in Louisville, Kentucky, is a complete business unit within Humana, Inc. and began offering pharmacy benefits in 1985. Today, HPS exclusively serves Humana plans to provide PBM services for more than 10 million enrollees across all Humana's books of business. HPS processes more than 500 million prescriptions annually and manages approximately $32 billion in prescription drug spend.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

Subcontractor Oversight

As we do in other Medicaid states, Humana will hold every subcontractor to full compliance with all applicable provisions of the LDH Contract by implementing our standardized selection, monitoring and oversight processes.

Experienced Partners

While Humana has responsibility for and will continue to perform a majority of the functions required by its Contract with LDH, we also understand the importance of choosing and maintaining high-quality subcontractor relationships where functional support is appropriate. Humana is committed to working with partners experienced in serving Medicaid enrollees and delivering services on behalf of our organization, with a focus on the Triple Aim of better health, better care, and lower costs. Prior to contracting, we evaluate our subcontractor candidates carefully, using a strategic and competitive procurement process. This includes internal and external cost analysis to optimize savings opportunities, a sourcing process that includes competitive bidding, contract negotiations, and implementation to ensure every potential partner satisfies all commercial, legal, and compliance standards. Ongoing monitoring and oversight includes all assessments and audits required by both regulation and contract at the time of functional delegation.

All Subcontractors Held to the State's Standards

All applicable legal, regulatory, and contract requirements flow to each subcontractor through the executed agreements specific to performed activities. Humana's robust subcontractor monitoring structure is coordinated across multiple teams at national and local levels. Our well-established delegation policies and procedures ensure consistency across Humana, and we require subcontractors to adhere to a formal Compliance Policy that contains written standards of conduct.

In Louisiana, local executive leadership will oversee the operations and performance of our subcontractors on a continuous basis, applying the LDH Contract requirements and Humana's national policies and procedures to local operations. A dedicated relationship manager for each subcontractor will be responsible for ongoing relationship maintenance and for monitoring subcontractors' performance in accordance with LDH Contract and Humana-specific requirements.

Regular Joint Operating Committee (JOC) meetings will be held with each subcontractor and relevant staff where performance will be assessed, and issues and opportunities will be escalated. Reporting and metrics are also a large part of the monitoring process. We track metrics and supply findings as specified by overseeing agencies, and if a subcontractor's performance does not meet performance standards, an improvement plan is developed and conducted with the subcontractor. All relevant information is submitted to overseeing agencies on their required timelines.

Subcontractor Training and Review Ensure Compliance

Humana will implement a subcontractor attestation process such that subcontractors who deliver services as part of the LDH Contract must certify they have completed all necessary training and fully understand the requirements of the LDH Contract, State and federal laws, and all other applicable requirements. Activities performed by all subcontractors will be under the control and direction of Humana, and our subcontractors can perform no activity without appropriate Humana review, approval, and ongoing formal oversight.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Louisiana Medicaid Addendum, pages 1-2, B.1.
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Louisiana Medicaid Addendum, page 7
3	Specify the effective dates of the subcontract agreement.	Louisiana Medicaid Addendum, page 1, second WHEREAS
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Louisiana Medicaid Addendum, page 2, B.2.
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Louisiana Medicaid Addendum, page 2, B.3.
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Louisiana Medicaid Addendum, page 2, B.4.
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Louisiana Medicaid Addendum, page 2, B.5.
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Louisiana Medicaid Addendum, page 2, B.6.
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Louisiana Medicaid Addendum, page 2, B.7.
10	Identify the population covered by the subcontract.	Louisiana Medicaid Addendum, page 2, B.8.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Louisiana Medicaid Addendum, page 2, B.9.
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Louisiana Medicaid Addendum, page 2, B.10.
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Louisiana Medicaid Addendum, page 2, B.11.
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Louisiana Medicaid Addendum, page 2, B.12.
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Louisiana Medicaid Addendum, page 2, B.13.
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Louisiana Medicaid Addendum, page 2, B.14.
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 3, B.15.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Louisiana Medicaid Addendum, page 3, B.16.
19	INTENTIONALLY LEFT BLANK	
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Louisiana Medicaid Addendum, page 4, B.18.
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Louisiana Medicaid Addendum, page 4, B.19.
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Louisiana Medicaid Addendum, page 4, B.20
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Louisiana Medicaid Addendum, page 4, B.21.
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Louisiana Medicaid Addendum, page 4, B.22.
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 4, B.23.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Louisiana Medicaid Addendum, page 4, B.24.
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Louisiana Medicaid Addendum, page 4, B.25.
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Louisiana Medicaid Addendum, page 4, B.26.
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Louisiana Medicaid Addendum, page 4, B.27.
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Louisiana Medicaid Addendum, page 4, B.28.
31	Specify that at all times during the term of the subcontract, thesubcontractor shall indemnify and hold LDH harmless from all claims, losses,or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by useof other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Louisiana Medicaid Addendum, page 4-5, B.29.
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Louisiana Medicaid Addendum, page 5, B.30.
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Louisiana Medicaid Addendum, page 5. B.31.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Louisiana Medicaid Addendum, page 5. B.32.
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Louisiana Medicaid Addendum, page 5. B.33.
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 5. B.34.
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Louisiana Medicaid Addendum, page 6. B.35
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Louisiana Medicaid Addendum, page 6. B.36.
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Louisiana Medicaid Addendum, page 6. B.37.
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Louisiana Medicaid Addendum, page 6. B.38.
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Louisiana Medicaid Addendum, page 6. B.39.
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Louisiana Medicaid Addendum, page 6. B.40.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Louisiana Medicaid Addendum, page 6. B.41.
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Louisiana Medicaid Addendum, page 3. B.16

LOUISIANA MEDICAID ADDENDUM

THIS LOUISIANA MEDICAID ADDENDUM is entered into by and between Humana Health Benefit Plan of Louisiana, Inc. (hereinafter referred to as "**Humana**") and [insert full legal name of Subcontractor], licensed under the laws of the State of Louisiana (hereinafter referred to as "**Subcontractor**"). **Humana** and **Subcontractor** may collectively be referred to as the "**Parties**."

The purpose of this Medicaid Addendum ("Addendum") is to ensure compliance with the Louisiana Department of Health ("LDH") program contract, laws, rules and regulations. This Addendum shall supersede any and all contradictory terms of the [insert title of parent agreement] (the "Agreement") made between the **Parties** to which this Addendum is a part. Any term not otherwise defined herein shall have the meaning given it in the Agreement or the Louisiana Medicaid Managed Care Organization contract between **Humana** and LDH (hereinafter the "LDH Contract").

WITNESSETH

WHEREAS, the **Parties** entered into the Agreement pursuant to which **Subcontractor** agreed to provide certain medical, management or other supporting services to **Humana** or its Members or providers at negotiated rates; and

WHEREAS, the Agreement between the **Parties** was effective as of [insert Agreement Effective Date]; and

WHEREAS, the **Parties** desire to incorporate **Humana's** Medicaid-participating Managed Care Plan, as defined in the LDH Contract, and the following additional related provisions as required by LDH. The following terms and conditions are intended to apply to Subcontractor because of its status as a Material Subcontractor as defined herein, and shall supplement the terms and conditions of the Agreement solely as they relate to Humana's participating Louisiana Medicaid Managed Care Plan.

Notwithstanding any provision of the Agreement or this Addendum, **Humana** maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the LDH Contract. No subcontract will operate to relieve Humana of its legal responsibilities under the LDH Contract.

A. Definitions

1. The definition of "Member" in the Agreement includes persons designated by **Humana** and covered under **Humana**'s Medicaid Managed Care Plan under its LDH Contract.

2. As defined in the LDH Contract, a "Material Subcontract" is any contract or agreement by which Humana procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of any program area or function that relates to the delivery or payment of Medicaid Managed Care Plan covered services including, but not limited to, behavioral health, claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers.

3. A "Material Subcontractor" has a contract with Humana to perform any of the services.

4. "MCO Manual" means a compilation of policies, instructions, and guidelines established by LDH for the administration of the Louisiana Medicaid managed care program.

   Medical providers that are also contracted or delegated to perform functions, services or responsibilities for providing services (e.g., claims processing) under the LDH Contract are deemed to be a Material Subcontractor.

B. Provisions and Obligations

1. **Subcontractor** shall adhere to all requirements in the LDH Contract applicable to subcontractors, a copy of which shall be furnished to **Subcontractor** upon request. The LDH Contract is comprised of and incorporates all provisions of the RFP for award of the MCO services to Humana and any addenda, appendices,

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attachments or amendments thereto, as well as any handbooks, the MCO Manual, and other applicable policy guides, manuals and materials.

2. The Agreement and its appendices, including this Addendum and any written delegation agreements contain all the terms and conditions agreed upon by the **Parties**.

3. No modification or change of any provision of the Agreement or this Addendum shall be made unless such modification is incorporated and attached as a written amendment to the Agreement and signed by the **Parties**.

4. No alteration, variation, modification, waiver, extension of the Agreement termination date, or early termination of the Agreement, shall be effective unless reduced to writing, duly executed by the **Parties,** and attached to the original of the Agreement.

5. **Humana** and **Subcontractor** acknowledge that in the event of termination of the LDH Contract between **Humana** and LDH for any of the reasons described in the LDH Contract, **Humana** shall immediately notify LDH in writing and make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to **Humana's** and **Subcontractor's** activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH.

6. **Subcontractor** shall not enter into any subcontract or other agreement for any of the work contemplated under the Agreement without the prior written approval of Humana, and LDH where applicable.

7. If any requirement in the Agreement is determined by LDH to conflict with the LDH Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

8. The **Parties** shall identify within the Agreement the Medicaid population covered by the Agreement.

9. The services provided under the Agreement shall be in accordance with the Louisiana Medicaid State Plan and **Subcontractor** shall provide the services to **Humana** Members/enrollees through the last day that the Agreement is in effect.

10. **Subcontractor** shall be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by **Humana**.

11. The Agreement shall specify the amount, duration, and scope of benefits and services that are provided by **Subcontractor**.

12. If applicable, emergency services shall be coordinated without the requirement of prior authorization of any kind.

13. If **Subcontractor** performs laboratory services, **Subcontractor** shall meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.

14. **Subcontractor** shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to **Humana** enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the LDH Contract). **Humana** enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended, and subject to reasonable charges.

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15. All documentation and/or records maintained by **Subcontractor**, and network providers as applicable, related to covered services, charges, operations and agreements under the Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall **Subcontractor** destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

    Subcontractor shall retain, as applicable, enrollee grievance and appeal records in 42C.F.R. §438.416, base data in 42 C.F.R. §438.5(c), MLR reports in 42 C.F.R. §438.8 (k), and the data, information, and documentation specified in 42 C.F.R. §438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

16. **Subcontractor,** for itself and its providers, agrees that they shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General Medicaid Fraud Control Unit ("MFCU"), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of MCOs but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be at no cost to the MFCU, and **Humana**, **Subcontractor** or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. **Humana**, **Subcontractor** and its providers agree that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

    Subcontractor shall comply with the audit and inspection requirements set forth in 42 C.F.R. §438.230(c)(3) and 42 C.F.R. §438.3(k). The state of Louisiana, including LDH, MFCU, Government Accountability Office, and the Louisiana Legislative Auditor ("LLA"), and the federal government, including CMS, Health and Humana Services ("HHS"), the U.S. Office of the Inspector General ("OIG"), and the General Accounting Office, or their designees, have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under the Agreement at any time. This right exists for ten (10) years from the termination of the LDH Contract, or from the date of completion of any audit, whichever is later; provided, however that if any of the entities above determine that there is a reasonable possibility of fraud or similar risk, they may audit, evaluate, and inspect at any time.

    Subcontractor shall make all premises, facilities, equipment, records, systems, program and financial records and service delivery sites open to the state of Louisiana, including LDH, MFCU, Government Accountability Office, and LLA, and the federal government, including CMS, HHS, OIG, and the General Accounting Office, and any of their designees upon request, for the purposes of any audit, evaluation, or inspection. **Subcontractor** shall provide these entities with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with **Subcontractor's** clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the LDH Contract. The rights of access in this provision are not limited to any retention periods, but shall last as long as records are retained. **Subcontractor** shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

17. Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs and LDH requires the same of **Humana** subcontractors. **Subcontractor** shall complete and submit to **Humana** the Medicaid Ownership and Disclosure form as required by LDH. The completed disclosure of ownership will be presented to LDH pursuant to its requirements.

18. **Subcontractor** shall participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by **Humana** and/or LDH or its designee, whether announced or unannounced.

19. **Subcontractor** shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which **Humana** and/or **Subcontractor** practices and/or the standards established by LDH or its designee.

20. **Subcontractor** shall comply with any corrective action plan initiated by **Humana** and/or as required by LDH.

21. **Humana** may assess monetary penalties, sanctions or reductions in payment on **Subcontractor** for failure to comply with the Agreement or credentialing requirements, up to and including Agreement termination. This shall include, but is not limited to **Subcontractor's** failure or refusal to respond to **Humana's** request for information, the request to provide medical records, credentialing information, and like requests at **Humana's** discretion or as a directive by LDH. **Humana** shall impose at a minimum, financial consequences against **Subcontractor** as appropriate.

22. **Subcontractor** shall submit all reports and clinical information to **Humana** for reporting purposes as required by LDH.

23. **Subcontractor** shall safeguard information about **Humana** enrollees according to applicable state and federal laws and regulations and as described in the LDH Contract.

24. The Agreement shall make full disclosure of the method and amount of compensation or other consideration to be received from **Humana** by **Subcontractor**.

25. If **Subcontractor** is delegated for claims processing, **Subcontractor** shall comply with LDH's claims processing requirements as stated in the RFP, LHD Contract, and MCO Manual. These provisions include, but are not limited to, Section 2.11 of the LDH Contract – Provider Reimbursement.

26. **Subcontractor** shall adhere to applicable timely filing guidelines set forth by LDH. These provisions include, but are not limited to, Section 2.18.7 of the LDH Contract.

27. If LDH, its subcontractors or **Humana** discover an error or a conflict with a previously adjudicated encounter claim, **Subcontractor** shall adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or **Humana**, or if circumstances exist that prevent **Subcontractor** from meeting this time frame, by a specified date approved by LDH.

28. **Subcontractor** shall accept the final payment made by **Humana** as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or **Humana** Members or enrollees. "Member" shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

29. Indemnity. Neither **Party** shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The **Parties** shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under the Agreement.

    Subcontractor shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and hold harmless the State of Louisiana and its Authorized Users (as defined in the LDH Contract) from suits, actions, damages and costs of every name and description relating to personal injury and damage to property caused by **Subcontractor**, its agents, employees, partners or subcontractors,

without limitation; provided, however, that **Subcontractor** shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the State.

Hold Harmless: Unless **Subcontractor** is a state agency, **Subcontractor** shall indemnify, defend, protect, and hold harmless LDH and any of its officers, agents, and employees from:

a) Any claims for damages or losses arising from services rendered by **Subcontractor,** or any person, or firm performing or supplying services, materials, or supplies for Subcontractor in connection with the performance of the Agreement;
b) Any claims for damages or losses arising from sanctions due to **Subcontractor's** network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the *Fraud, Waste, and Abuse Prevention* Section of the LDH Contract.
c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by **Subcontractor**, its agents, officers, employees, or subcontractors in the performance of the Agreement;
d) Any claims for damages or losses resulting to any person or firm injured or damaged by **Subcontractor**, its agents, officers, employees, or subcontractors by **Subcontractor's** publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the LDH Contract, or by federal or state regulations or statutes;
e) Any claims for damages or losses arising from failure by **Subcontractor**, its agents, officers, employees, or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;
f) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to **Subcontractor** by Humana;
g) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and
h) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against LDH or their agents, officers, or employees, through the intentional conduct, negligence, or omission of **Subcontractor**, its agents, officers, employees, or subcontractors.

30. **Subcontractor** shall secure all applicable liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect **Humana** and its enrollees as stated in the Agreement. **Subcontractor** shall maintain such insurance coverage upon execution of the Agreement and at all times during the Agreement term and shall furnish **Humana** with written verification of the existence of such coverage.

31. **Subcontractor** shall recognize and abide by all state and federal laws (including Medicaid laws), rules, regulations, guidelines, and subregulatory guidance, applicable to the provision of services. **Subcontractor** and **Humana** stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where **Subcontractor** is based and Louisiana law.

32. The Agreement and this Addendum incorporate by reference all applicable federal and state laws, rules and regulations. Any revisions of such laws, rules, or regulations shall automatically be incorporated into the Agreement as they become effective.

33. **Humana** and **Subcontractor** shall be responsible for resolving any disputes that may arise between the **Parties**, and no dispute shall disrupt or interfere with the provision of services to a **Humana** Member.\

34. **Subcontractor** shall sign the no conflict of interest form in compliance with the requirements of the LDH Contract.

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35. To the extent applicable, **Subcontractor** shall adhere to the Quality Assessment Performance Improvement ("QAPI") and Utilization Management ("UM") requirements as stated the LDH Contract. The QAPI and UM requirements shall be included as part of the Agreement.

36. **Subcontractor** shall give **Humana** immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on **Subcontractor's** ability to perform the services in the Agreement.

37. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), **Subcontractor** shall take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

38. **Humana** shall not restrict **Subcontractor** from subcontracting with another MCO or other managed care entity.

39. If **Humana** has entered into an alternative reimbursement arrangement with **Subcontractor**, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by **Humana**.

40. Services to be provided under the Agreement shall be performed entirely within the boundaries of the United States, which includes the fifty (50) states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, **Subcontractor** shall not hire any individual to perform any services under the LDH Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

41. **Subcontractor**, for itself and its providers, hereby assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, "Subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

42. **Humana** shall monitor **Subcontractor's** performance on an ongoing basis and perform a formal review annually. The annual review shall include any performance concerns identified by Humana or LDH. If any deficiencies or areas for improvement are identified, **Subcontractor** shall take corrective action**. Humana** shall provide LDH with a copy of the annual review and any corrective action plans developed as a result and provide ongoing updates to LDH on **Subcontractor's** activities to improve its performance. **Subcontractor** shall provide Humana with updated information and action plans as required to provide ongoing updates to LDH.

43. **Subcontractor** acknowledges and agrees to comply with the provision of R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under the Agreement.

44. **Subcontractor** certifies that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving federal funds or grants from the Federal Government. **Subcontractor** certifies that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689. "Debarment and Suspension," as set forth at 24 CFR Part 24 and "Nonprocurement Debarment and Suspension" set forth at 2 CFR Part 2424. **Subcontractor** has a continuing obligation to disclose any suspension or debarment by any government entity, including but not limited to the General Services Administration ("GSA"). Failure to disclose may constitute grounds for suspension and/or termination of the Agreement and debarment from future state contracts.

45. Claims for services furnished or requested for reimbursement by **Subcontractor** which are not provided for in the Agreement shall not be allowed by **Humana**. In the event it is determined that certain costs which have

been reimbursed to **Subcontractor** pursuant to the Agreement are not allowable, **Humana** shall have the right to set off and withhold said amounts from any amount due **Subcontractor** under the Agreement for costs that are allowable.

46. **Subcontractor** hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for services which are rendered to such enrollees by **Subcontractor** and which are **Humana** covered services.

The **Parties** have the authority necessary to bind all of the entities identified here and have executed this Addendum to be effective as of [insert effective date of Medicaid terms].

ICMVendorName	**HUMANA**
Signature:	**Signature:**
Name: ExternalSignatory	**Name:** InternalSignatory
Title: ExternalSignatoryTitle	**Title:** InternalSignatoryTitle
Date:	**Date:**

Approved as to Form : ICMAgreementCode

Exhibit B: Material Subcontractor Response Template

Proposer (MCO) name:
Humana Health Benefit Plan of Louisiana, Inc. (Humana)
Material subcontractor name:
Superior Vision Benefit Management, Inc. (Superior Vision)
Description of the Proposer's role and material subcontractor's role:
While Humana will deliver the majority of services to enrollees and providers under the Contract, we have subcontracted certain services to third party vendors. Superior Vision is delegated for Vision benefit management services.
Explanation of why the Proposer plans to subcontract this service and/or function:
We are committed to providing the highest quality services to our membership. After a thorough evaluation, we have determined that Superior Vision is best positioned to offer Vision benefit management services under the Contract.
A description of the material subcontractor's organizational experience:
Superior Vision Benefit Management, Inc. (Superior Vision) has more than 25 years of experience managing vision benefits on behalf of health plans (with an emphasis on government programs) Together with affiliates, our company currently manages vision benefits on behalf of 37.9 million members nationwide. Since 1994, Superior Vision has delivered a full-spectrum of vision care services ranging from routine to medical/surgical on behalf of government-sponsored health plans. Today, we provide services to 120 health plan clients in 22 states covering more than 18 million Medicaid, CHIP, and Medicare Advantage members. Superior Vision is the largest administrator of vision benefits for government-sponsored health plans in the nation. In Louisiana, Superior Vision has administered vision services for the Medicaid and CHIP programs since the start of managed care in 2012. Superior Vision currently provides comprehensive routine vision and medical eye care services to more than 425,000 Louisiana Medicaid and CHIP members. Our long-term experience managing services on behalf of Medicaid, CHIP and Medicare Advantage programs makes Superior Vision uniquely qualified to deliver outstanding service to the Louisiana Department of Health and valued members.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

Subcontractor Oversight

As we do in other Medicaid states, Humana will hold every subcontractor to full compliance with all applicable provisions of the LDH Contract by implementing our standardized selection, monitoring and oversight processes.

Experienced Partners

While Humana has responsibility for and will continue to perform a majority of the functions required by its Contract with LDH, we also understand the importance of choosing and maintaining high-quality subcontractor relationships where functional support is appropriate. Humana is committed to working with partners experienced in serving Medicaid enrollees and delivering services on behalf of our organization, with a focus on the Triple Aim of better health, better care, and lower costs. Prior to contracting, we evaluate our subcontractor candidates carefully, using a strategic and competitive procurement process. This includes internal and external cost analysis to optimize savings opportunities, a sourcing process that includes competitive bidding, contract negotiations, and implementation to ensure every potential partner satisfies all commercial, legal, and compliance standards. Ongoing monitoring and oversight includes all assessments and audits required by both regulation and contract at the time of functional delegation.

All Subcontractors Held to the State's Standards

All applicable legal, regulatory, and contract requirements flow to each subcontractor through the executed agreements specific to performed activities. Humana's robust subcontractor monitoring structure is coordinated across multiple teams at national and local levels. Our well-established delegation policies and procedures ensure consistency across Humana, and we require subcontractors to adhere to a formal Compliance Policy that contains written standards of conduct.

In Louisiana, local executive leadership will oversee the operations and performance of our subcontractors on a continuous basis, applying the LDH Contract requirements and Humana's national policies and procedures to local operations. A dedicated relationship manager for each subcontractor will be responsible for ongoing relationship maintenance and for monitoring subcontractors' performance in accordance with LDH Contract and Humana-specific requirements.

Regular Joint Operating Committee (JOC) meetings will be held with each subcontractor and relevant staff where performance will be assessed, and issues and opportunities will be escalated. Reporting and metrics are also a large part of the monitoring process. We track metrics and supply findings as specified by overseeing agencies, and if a subcontractor's performance does not meet performance standards, an improvement plan is developed and conducted with the subcontractor. All relevant information is submitted to overseeing agencies on their required timelines.

Subcontractor Training and Review Ensure Compliance

Humana will implement a subcontractor attestation process such that subcontractors who deliver services as part of the LDH Contract must certify they have completed all necessary training and fully understand the requirements of the LDH Contract, State and federal laws, and all other applicable requirements. Activities performed by all subcontractors will be under the control and direction of Humana, and our subcontractors can perform no activity without appropriate Humana review, approval, and ongoing formal oversight.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Louisiana Medicaid Addendum, pages 1-2, B.1.
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Louisiana Medicaid Addendum, page 7
3	Specify the effective dates of the subcontract agreement.	Louisiana Medicaid Addendum, page 1, second WHEREAS
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Louisiana Medicaid Addendum, page 2, B.2.
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Louisiana Medicaid Addendum, page 2, B.3.
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Louisiana Medicaid Addendum, page 2, B.4.
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Louisiana Medicaid Addendum, page 2, B.5.
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Louisiana Medicaid Addendum, page 2, B.6.
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Louisiana Medicaid Addendum, page 2, B.7.
10	Identify the population covered by the subcontract.	Louisiana Medicaid Addendum, page 2, B.8.
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Louisiana Medicaid Addendum, page 2, B.9.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Louisiana Medicaid Addendum, page 2, B.10.
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Louisiana Medicaid Addendum, page 2, B.11.
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Louisiana Medicaid Addendum, page 2, B.12.
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Louisiana Medicaid Addendum, page 2, B.13.
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Louisiana Medicaid Addendum, page 2, B.14.
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 3, B.15.
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Louisiana Medicaid Addendum, page 3, B.16.
19	INTENTIONALLY LEFT BLANK	

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Louisiana Medicaid Addendum, page 4, B.18.
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Louisiana Medicaid Addendum, page 4, B.19.
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Louisiana Medicaid Addendum, page 4, B.20
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Louisiana Medicaid Addendum, page 4, B.21.
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Louisiana Medicaid Addendum, page 4, B.22.
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 4, B.23.
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Louisiana Medicaid Addendum, page 4, B.24.
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Louisiana Medicaid Addendum, page 4, B.25.
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Louisiana Medicaid Addendum, page 4, B.26.
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Louisiana Medicaid Addendum, page 4, B.27.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Louisiana Medicaid Addendum, page 4, B.28.
31	Specify that at all times during the term of the subcontract, thesubcontractor shall indemnify and hold LDH harmless from all claims, losses,or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by useof other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Louisiana Medicaid Addendum, page 4-5, B.29.
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Louisiana Medicaid Addendum, page 5, B.30.
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Louisiana Medicaid Addendum, page 5. B.31.
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Louisiana Medicaid Addendum, page 5. B.32.
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Louisiana Medicaid Addendum, page 5. B.33.
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Louisiana Medicaid Addendum, page 5. B.34.
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Louisiana Medicaid Addendum, page 6. B.35

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Louisiana Medicaid Addendum, page 6. B.36.
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Louisiana Medicaid Addendum, page 6. B.37.
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Louisiana Medicaid Addendum, page 6. B.38.
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Louisiana Medicaid Addendum, page 6. B.39.
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Louisiana Medicaid Addendum, page 6. B.40.
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Louisiana Medicaid Addendum, page 6. B.41.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Louisiana Medicaid Addendum, page 3. B.16

LOUISIANA MEDICAID ADDENDUM

THIS LOUISIANA MEDICAID ADDENDUM is entered into by and between Humana Health Benefit Plan of Louisiana, Inc. (hereinafter referred to as "**Humana**") and [insert full legal name of Subcontractor], licensed under the laws of the State of Louisiana (hereinafter referred to as "**Subcontractor**"). **Humana** and **Subcontractor** may collectively be referred to as the "**Parties**."

The purpose of this Medicaid Addendum ("Addendum") is to ensure compliance with the Louisiana Department of Health ("LDH") program contract, laws, rules and regulations. This Addendum shall supersede any and all contradictory terms of the [insert title of parent agreement] (the "Agreement") made between the **Parties** to which this Addendum is a part. Any term not otherwise defined herein shall have the meaning given it in the Agreement or the Louisiana Medicaid Managed Care Organization contract between **Humana** and LDH (hereinafter the "LDH Contract").

WITNESSETH

WHEREAS, the **Parties** entered into the Agreement pursuant to which **Subcontractor** agreed to provide certain medical, management or other supporting services to **Humana** or its Members or providers at negotiated rates; and

WHEREAS, the Agreement between the **Parties** was effective as of [insert Agreement Effective Date]; and

WHEREAS, the **Parties** desire to incorporate **Humana's** Medicaid-participating Managed Care Plan, as defined in the LDH Contract, and the following additional related provisions as required by LDH. The following terms and conditions are intended to apply to Subcontractor because of its status as a Material Subcontractor as defined herein, and shall supplement the terms and conditions of the Agreement solely as they relate to Humana's participating Louisiana Medicaid Managed Care Plan.

Notwithstanding any provision of the Agreement or this Addendum, **Humana** maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the LDH Contract. No subcontract will operate to relieve Humana of its legal responsibilities under the LDH Contract.

A. Definitions

1. The definition of "Member" in the Agreement includes persons designated by **Humana** and covered under **Humana**'s Medicaid Managed Care Plan under its LDH Contract.

2. As defined in the LDH Contract, a "Material Subcontract" is any contract or agreement by which Humana procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of any program area or function that relates to the delivery or payment of Medicaid Managed Care Plan covered services including, but not limited to, behavioral health, claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers.

3. A "Material Subcontractor" has a contract with Humana to perform any of the services.

4. "MCO Manual" means a compilation of policies, instructions, and guidelines established by LDH for the administration of the Louisiana Medicaid managed care program.

   Medical providers that are also contracted or delegated to perform functions, services or responsibilities for providing services (e.g., claims processing) under the LDH Contract are deemed to be a Material Subcontractor.

B. Provisions and Obligations

1. **Subcontractor** shall adhere to all requirements in the LDH Contract applicable to subcontractors, a copy of which shall be furnished to **Subcontractor** upon request. The LDH Contract is comprised of and incorporates all provisions of the RFP for award of the MCO services to Humana and any addenda, appendices,

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attachments or amendments thereto, as well as any handbooks, the MCO Manual, and other applicable policy guides, manuals and materials.

2. The Agreement and its appendices, including this Addendum and any written delegation agreements contain all the terms and conditions agreed upon by the **Parties**.

3. No modification or change of any provision of the Agreement or this Addendum shall be made unless such modification is incorporated and attached as a written amendment to the Agreement and signed by the **Parties**.

4. No alteration, variation, modification, waiver, extension of the Agreement termination date, or early termination of the Agreement, shall be effective unless reduced to writing, duly executed by the **Parties,** and attached to the original of the Agreement.

5. **Humana** and **Subcontractor** acknowledge that in the event of termination of the LDH Contract between **Humana** and LDH for any of the reasons described in the LDH Contract, **Humana** shall immediately notify LDH in writing and make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to **Humana's** and **Subcontractor's** activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH.

6. **Subcontractor** shall not enter into any subcontract or other agreement for any of the work contemplated under the Agreement without the prior written approval of Humana, and LDH where applicable.

7. If any requirement in the Agreement is determined by LDH to conflict with the LDH Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

8. The **Parties** shall identify within the Agreement the Medicaid population covered by the Agreement.

9. The services provided under the Agreement shall be in accordance with the Louisiana Medicaid State Plan and **Subcontractor** shall provide the services to **Humana** Members/enrollees through the last day that the Agreement is in effect.

10. **Subcontractor** shall be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by **Humana**.

11. The Agreement shall specify the amount, duration, and scope of benefits and services that are provided by **Subcontractor**.

12. If applicable, emergency services shall be coordinated without the requirement of prior authorization of any kind.

13. If **Subcontractor** performs laboratory services, **Subcontractor** shall meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.

14. **Subcontractor** shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to **Humana** enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the LDH Contract). **Humana** enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended, and subject to reasonable charges.

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15. All documentation and/or records maintained by **Subcontractor**, and network providers as applicable, related to covered services, charges, operations and agreements under the Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall **Subcontractor** destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

    Subcontractor shall retain, as applicable, enrollee grievance and appeal records in 42C.F.R. §438.416, base data in 42 C.F.R. §438.5(c), MLR reports in 42 C.F.R. §438.8 (k), and the data, information, and documentation specified in 42 C.F.R. §438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

16. **Subcontractor,** for itself and its providers, agrees that they shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General Medicaid Fraud Control Unit ("MFCU"), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of MCOs but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be at no cost to the MFCU, and **Humana**, **Subcontractor** or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. **Humana**, **Subcontractor** and its providers agree that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

    Subcontractor shall comply with the audit and inspection requirements set forth in 42 C.F.R. §438.230(c)(3) and 42 C.F.R. §438.3(k). The state of Louisiana, including LDH, MFCU, Government Accountability Office, and the Louisiana Legislative Auditor ("LLA"), and the federal government, including CMS, Health and Humana Services ("HHS"), the U.S. Office of the Inspector General ("OIG"), and the General Accounting Office, or their designees, have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under the Agreement at any time. This right exists for ten (10) years from the termination of the LDH Contract, or from the date of completion of any audit, whichever is later; provided, however that if any of the entities above determine that there is a reasonable possibility of fraud or similar risk, they may audit, evaluate, and inspect at any time.

    Subcontractor shall make all premises, facilities, equipment, records, systems, program and financial records and service delivery sites open to the state of Louisiana, including LDH, MFCU, Government Accountability Office, and LLA, and the federal government, including CMS, HHS, OIG, and the General Accounting Office, and any of their designees upon request, for the purposes of any audit, evaluation, or inspection. **Subcontractor** shall provide these entities with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with **Subcontractor's** clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the LDH Contract. The rights of access in this provision are not limited to any retention periods, but shall last as long as records are retained. **Subcontractor** shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

17. Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs and LDH requires the same of **Humana** subcontractors. **Subcontractor** shall complete and submit to **Humana** the Medicaid Ownership and Disclosure form as required by LDH. The completed disclosure of ownership will be presented to LDH pursuant to its requirements.

18. **Subcontractor** shall participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by **Humana** and/or LDH or its designee, whether announced or unannounced.

19. **Subcontractor** shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which **Humana** and/or **Subcontractor** practices and/or the standards established by LDH or its designee.

20. **Subcontractor** shall comply with any corrective action plan initiated by **Humana** and/or as required by LDH.

21. **Humana** may assess monetary penalties, sanctions or reductions in payment on **Subcontractor** for failure to comply with the Agreement or credentialing requirements, up to and including Agreement termination. This shall include, but is not limited to **Subcontractor's** failure or refusal to respond to **Humana's** request for information, the request to provide medical records, credentialing information, and like requests at **Humana's** discretion or as a directive by LDH. **Humana** shall impose at a minimum, financial consequences against **Subcontractor** as appropriate.

22. **Subcontractor** shall submit all reports and clinical information to **Humana** for reporting purposes as required by LDH.

23. **Subcontractor** shall safeguard information about **Humana** enrollees according to applicable state and federal laws and regulations and as described in the LDH Contract.

24. The Agreement shall make full disclosure of the method and amount of compensation or other consideration to be received from **Humana** by **Subcontractor**.

25. If **Subcontractor** is delegated for claims processing, **Subcontractor** shall comply with LDH's claims processing requirements as stated in the RFP, LHD Contract, and MCO Manual. These provisions include, but are not limited to, Section 2.11 of the LDH Contract – Provider Reimbursement.

26. **Subcontractor** shall adhere to applicable timely filing guidelines set forth by LDH. These provisions include, but are not limited to, Section 2.18.7 of the LDH Contract.

27. If LDH, its subcontractors or **Humana** discover an error or a conflict with a previously adjudicated encounter claim, **Subcontractor** shall adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or **Humana**, or if circumstances exist that prevent **Subcontractor** from meeting this time frame, by a specified date approved by LDH.

28. **Subcontractor** shall accept the final payment made by **Humana** as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or **Humana** Members or enrollees. "Member" shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

29. Indemnity. Neither **Party** shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The **Parties** shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under the Agreement.

    Subcontractor shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and hold harmless the State of Louisiana and its Authorized Users (as defined in the LDH Contract) from suits, actions, damages and costs of every name and description relating to personal injury and damage to property caused by **Subcontractor**, its agents, employees, partners or subcontractors,

without limitation; provided, however, that **Subcontractor** shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the State.

Hold Harmless: Unless **Subcontractor** is a state agency, **Subcontractor** shall indemnify, defend, protect, and hold harmless LDH and any of its officers, agents, and employees from:

a) Any claims for damages or losses arising from services rendered by **Subcontractor,** or any person, or firm performing or supplying services, materials, or supplies for Subcontractor in connection with the performance of the Agreement;
b) Any claims for damages or losses arising from sanctions due to **Subcontractor's** network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the *Fraud, Waste, and Abuse Prevention* Section of the LDH Contract.
c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by **Subcontractor**, its agents, officers, employees, or subcontractors in the performance of the Agreement;
d) Any claims for damages or losses resulting to any person or firm injured or damaged by **Subcontractor**, its agents, officers, employees, or subcontractors by **Subcontractor's** publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the LDH Contract, or by federal or state regulations or statutes;
e) Any claims for damages or losses arising from failure by **Subcontractor**, its agents, officers, employees, or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;
f) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to **Subcontractor** by Humana;
g) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and
h) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against LDH or their agents, officers, or employees, through the intentional conduct, negligence, or omission of **Subcontractor**, its agents, officers, employees, or subcontractors.

30. **Subcontractor** shall secure all applicable liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect **Humana** and its enrollees as stated in the Agreement. **Subcontractor** shall maintain such insurance coverage upon execution of the Agreement and at all times during the Agreement term and shall furnish **Humana** with written verification of the existence of such coverage.

31. **Subcontractor** shall recognize and abide by all state and federal laws (including Medicaid laws), rules, regulations, guidelines, and subregulatory guidance, applicable to the provision of services. **Subcontractor** and **Humana** stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where **Subcontractor** is based and Louisiana law.

32. The Agreement and this Addendum incorporate by reference all applicable federal and state laws, rules and regulations. Any revisions of such laws, rules, or regulations shall automatically be incorporated into the Agreement as they become effective.

33. **Humana** and **Subcontractor** shall be responsible for resolving any disputes that may arise between the **Parties**, and no dispute shall disrupt or interfere with the provision of services to a **Humana** Member.\

34. **Subcontractor** shall sign the no conflict of interest form in compliance with the requirements of the LDH Contract.

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35. To the extent applicable, **Subcontractor** shall adhere to the Quality Assessment Performance Improvement ("QAPI") and Utilization Management ("UM") requirements as stated the LDH Contract. The QAPI and UM requirements shall be included as part of the Agreement.

36. **Subcontractor** shall give **Humana** immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on **Subcontractor's** ability to perform the services in the Agreement.

37. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), **Subcontractor** shall take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

38. **Humana** shall not restrict **Subcontractor** from subcontracting with another MCO or other managed care entity.

39. If **Humana** has entered into an alternative reimbursement arrangement with **Subcontractor**, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by **Humana**.

40. Services to be provided under the Agreement shall be performed entirely within the boundaries of the United States, which includes the fifty (50) states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, **Subcontractor** shall not hire any individual to perform any services under the LDH Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

41. **Subcontractor**, for itself and its providers, hereby assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, "Subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

42. **Humana** shall monitor **Subcontractor's** performance on an ongoing basis and perform a formal review annually. The annual review shall include any performance concerns identified by Humana or LDH. If any deficiencies or areas for improvement are identified, **Subcontractor** shall take corrective action**. Humana** shall provide LDH with a copy of the annual review and any corrective action plans developed as a result and provide ongoing updates to LDH on **Subcontractor's** activities to improve its performance. **Subcontractor** shall provide Humana with updated information and action plans as required to provide ongoing updates to LDH.

43. **Subcontractor** acknowledges and agrees to comply with the provision of R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under the Agreement.

44. **Subcontractor** certifies that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving federal funds or grants from the Federal Government. **Subcontractor** certifies that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689. "Debarment and Suspension," as set forth at 24 CFR Part 24 and "Nonprocurement Debarment and Suspension" set forth at 2 CFR Part 2424. **Subcontractor** has a continuing obligation to disclose any suspension or debarment by any government entity, including but not limited to the General Services Administration ("GSA"). Failure to disclose may constitute grounds for suspension and/or termination of the Agreement and debarment from future state contracts.

45. Claims for services furnished or requested for reimbursement by **Subcontractor** which are not provided for in the Agreement shall not be allowed by **Humana**. In the event it is determined that certain costs which have

been reimbursed to **Subcontractor** pursuant to the Agreement are not allowable, **Humana** shall have the right to set off and withhold said amounts from any amount due **Subcontractor** under the Agreement for costs that are allowable.

46. **Subcontractor** hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for services which are rendered to such enrollees by **Subcontractor** and which are **Humana** covered services.

The **Parties** have the authority necessary to bind all of the entities identified here and have executed this Addendum to be effective as of [insert effective date of Medicaid terms].

ICMVendorName	**HUMANA**
Signature:	**Signature:**
Name: ExternalSignatory	**Name:** InternalSignatory
Title: ExternalSignatoryTitle	**Title:** InternalSignatoryTitle
Date:	**Date:**

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The Youth Empowerment Project (YEP), YEP Educates Program, provides the high school equivalency preparations and necessary supports to ensure Angel has equal access to educational opportunities. Humana provided a COVID-19 relief grant for YEP to continue operations during the COVID-19 pandemic.

Section 2.5.5

Financial Condition

Humana

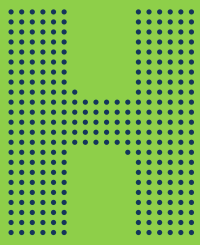
Healthy Horizons™
in Louisiana

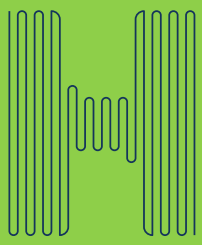
2.5.5 2.5.5 Financial Condition

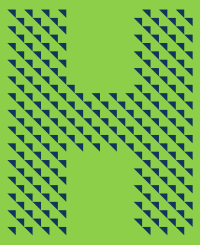
2.5.5.1 Demonstrating Financial Capability: Humana Health Benefit Plan of Louisiana, Inc. has adequate financial resources for performance as demonstrated by the audited financial statement listed below and are available electronically:

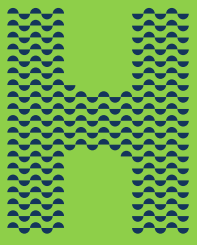
- **Attachment 2.5.5.1-1** HHBPLA 2020 Financial Statements .pdf
- **Attachment 2.5.5.1-2** HHBPLA 2019 Financial Statements .pdf
- **Attachment 2.5.5.1-3** HHBPLA 2018 Financial Statements .pdf
- **Attachment 2.5.5.1-4** HIC 2020 Financial Statements.pdf
- **Attachment 2.5.5.1-5** HIC 2019 Financial Statements.pdf
- **Attachment 2.5.5.1-6** HIC 2018 Financial Statements.pdf
- **Attachment 2.5.5.1-7** Humana Inc. 2020 Financial Statements.pdf
- **Attachment 2.5.5.1-8** Humana Inc. 2019 Financial Statements.pdf
- **Attachment 2.5.5.1-9** Humana Inc. 2018 Financial Statements.pdf

2.5.5.1.2 Certificate from Taxing Authority: Per **Addendum 4 - Proposer Inquiries** released on August 13th, 2021, this certificate is no longer requested for submission.









2.5.5 Financial Condition

Attachment 2.5.5.1-1 HHBPLA 2020 Financial Statements
Attachment 2.5.5.1-2 HHBPLA 2019 Financial Statements
Attachment 2.5.5.1-3 HHBPLA 2018 Financial Statements
Attachment 2.5.5.1-4 HIC 2020 Financial Statements
Attachment 2.5.5.1-5 HIC 2019 Financial Statements
Attachment 2.5.5.1-6 HIC 2018 Financial Statements
Attachment 2.5.5.1-7 Humana Inc. 2020 Financial Statements
Attachment 2.5.5.1-8 Humana Inc. 2019 Financial Statements
Attachment 2.5.5.1-9 Humana Inc. 2018 Financial Statements

(Provided Electronically)

Humana Health Benefit Plan of Louisiana, Inc.

(a wholly owned subsidiary of Humana Insurance Company, a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2020 and 2019

Humana Health Benefit Plan of Louisiana, Inc.
Index
Statutory Basis of Accounting
December 31, 2020 and 2019

Page

Report of Independent Auditors 1

Financial Statements

Statements of Admitted Assets, Liabilities and Surplus 3

Statements of Revenue and Expenses 4

Statements of Changes in Surplus 5

Statements of Cash Flows 6

Notes to Financial Statements 7

Supplemental Investment Information

Investment Risk Interrogatories 42

Summary Investment Schedule 51

Report of Independent Auditors

To the Board of Directors of Humana Health Benefit Plan of Louisiana, Inc.

We have audited the accompanying statutory financial statements of Humana Health Benefit Plan of Louisiana, Inc., which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2020 and 2019, and the related statutory statements of revenue and expenses and changes in surplus, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the state of Louisiana. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

PricewaterhouseCoopers LLP, 500 West Main Street, Ste. 1800, Louisville, KY 40202-2941
T: (502) 589 6100, F: (502) 585 7875, www.pwc.com/us

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2020 and 2019, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana described in Note 2.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements taken as a whole. The supplemental investment risk interrogatories and summary investment schedule (collectively, the "supplemental schedules") of the Company, as of December 31, 2020 and for the year then ended are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the statutory-basis financial statements. The supplemental schedules are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The supplemental schedules have been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental schedules are fairly stated, in all material respects, in relation to the statutory-basis financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 29, 2021

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Admitted Assets		
Cash and invested assets		
Bonds	$ 452,035,075	$ 404,723,770
Receivable for securities	16,750	5,431
Short-term investments	-	1,500,305
Total invested assets	452,051,825	406,229,506
Cash	69,140	(3,000,915)
Cash equivalents	119,112,724	26,303,500
Total cash and invested assets	571,233,689	429,532,091
Premiums receivable	32,786,060	33,027,843
Investment income due and accrued	4,067,856	3,954,602
Amounts receivable relating to uninsured plans	11,293,207	8,444,091
Health care and other receivables	39,667,833	34,840,491
Net deferred tax assets	6,223,976	4,245,695
Electronic data processing equipment and software, less accumulated depreciation of $4,813 and $0 in 2020 and 2019, respectively	72,193	-
Furniture and equipment, less accumulated depreciation of $842,812 and $701,078 in 2020 and 2019, respectively	719,533	775,406
Receivable from Humana Inc.	8,188,052	16,197,204
Total admitted assets	$ 674,252,399	$ 531,017,423
Liabilities		
Benefits and loss adjustment expenses payable	$ 282,873,684	$ 210,151,227
Aggregate health policy reserves	22,651,755	20,481,174
Aggregate health claim reserves	236,869	142,000
Advance premiums	6,807,644	5,084,272
Accounts payable and accrued expenses	15,655,093	12,104,169
Current federal income tax payable	938,452	3,419,725
Total liabilities	329,163,497	251,382,567
Surplus		
Common stock, $0 par value; $1 per share stated value; 1,000 shares authorized; 1,000 shares issued and outstanding	1,000	1,000
Special surplus - projected HCRL fee assessment	-	44,204,567
Paid-in surplus	66,400,346	66,400,346
Unassigned surplus	278,687,556	169,028,943
Total surplus	345,088,902	279,634,856
Total liabilities and surplus	$ 674,252,399	$ 531,017,423

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Earned premiums	$ 2,582,581,489	$ 2,250,677,753
Expenses		
Benefits incurred and loss adjustment expenses	2,173,613,296	1,967,334,040
Selling, general and administrative expenses	281,412,042	199,602,237
Changes in aggregate health policy reserves	1,950,870	1,605,000
Total expenses	2,456,976,208	2,168,541,277
Net underwriting gain	125,605,281	82,136,476
Net investment income	10,682,504	13,201,421
Net realized capital (losses) gains on investments (net of capital gains tax of $458,917 and $37,154, respectively)	(253,385)	139,768
Net other income (expense)	64,828	(239,814)
Income before federal income tax expense	136,099,228	95,237,851
Federal income tax expense	36,709,614	20,603,283
Net income	$ 99,389,614	$ 74,634,568

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2020 and 2019

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2019	1,000	$ 1,000	$ -	$ 65,760,152	$ 187,105,363	$ 252,866,515
Net income	-	-	-	-	74,634,568	74,634,568
Projected HCRL fee assessment	-	-	44,204,567	-	(44,204,567)	-
Change in net unrealized capital gain, less capital gains tax of $0	-	-	-	-	148,313	148,313
Change in net deferred income taxes	-	-	-	-	1,202,134	1,202,134
Change in nonadmitted assets	-	-	-	-	143,132	143,132
Forgiveness of payable from Humana Inc.	-	-	-	640,194	-	640,194
Dividends or return of capital paid	-	-	-	-	(50,000,000)	(50,000,000)
Balances at December 31, 2019	1,000	1,000	44,204,567	66,400,346	169,028,943	279,634,856
Net income	-	-	-	-	99,389,614	99,389,614
HCRL fee moratorium	-	-	(44,204,567)	-	44,204,567	-
Change in net deferred income taxes	-	-	-	-	2,009,914	2,009,914
Change in nonadmitted assets	-	-	-	-	(8,445,482)	(8,445,482)
Dividends or return of capital paid	-	-	-	-	(27,500,000)	(27,500,000)
Balances at December 31, 2020	1,000	$ 1,000	$ -	$ 66,400,346	$ 278,687,556	$ 345,088,902

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Cash flows from operations		
Premiums collected	$ 2,584,551,650	$ 2,239,951,121
Net investment income received	14,787,237	17,322,837
Benefits paid	(2,029,002,548)	(1,854,576,373)
Selling, general and administrative expenses paid	(362,554,924)	(283,011,596)
Federal income taxes paid	(39,649,804)	(15,744,914)
Net cash from operations	168,131,611	103,941,075
Cash flows from investments		
Proceeds from investments sold or matured	137,285,072	93,515,823
Cost of investments acquired	(188,620,151)	(59,912,657)
Net cash (used for) from investments	(51,335,079)	33,603,166
Cash flows from financing and miscellaneous sources		
Dividends or returns of capital paid	(27,500,000)	(50,000,000)
Other cash provided (applied)	5,082,442	(60,218,398)
Net cash used for financing and miscellaneous sources	(22,417,558)	(110,218,398)
Net change in cash, cash equivalents and short-term investments	94,378,974	27,325,843
Cash, cash equivalents and short-term investments		
Beginning of year	24,802,890	(2,522,953)
End of year	$ 119,181,864	$ 24,802,890

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

1. Reporting Entity

Humana Health Benefit Plan of Louisiana, Inc. (the Company), a wholly owned subsidiary of Humana Insurance Company (HIC), a wholly owned subsidiary of CareNetwork, Inc. (CNI), a wholly owned subsidiary of Humana Inc. (Humana), is a health maintenance organization (HMO) domiciled in the state of Louisiana and is authorized to sell health plan products therein. The Company is subject to regulation by the federal government and the Louisiana Department of Insurance (the Department). State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 7, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 6.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 10(a).

As part of the Company's individual Medicare Advantage products, it also offers Dual Eligible Special Needs (D-SNP) plans. In connection with offering a D-SNP plan in a particular state, the Company is required to enter into a special coordinating contract with the applicable state Medicaid agency.

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the Department, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(m), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Comprehensive income disclosures required by GAAP are omitted; and

viii. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

ix. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The Department adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The Department has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. The Commissioner of Insurance of the State of Louisiana allows the Company to admit its furniture and equipment used for Health Maintenance Organization operations, which is not in accordance with NAIC SSAP. The omission of this prescribed practice would have had no impact to the results of the Company's risk-based capital calculations.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The statutory financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department. A reconciliation of the Company's net income and surplus based on practices prescribed by the Department to net income and surplus based on Codification at December 31, 2020 and 2019 is shown below:

	2020	2019
Net Income – State of Louisiana basis	$ 99,389,614	$ 74,634,568
State prescribed or permitted practices	-	-
Net Income – Codification	$ 99,389,614	$ 74,634,568
Surplus – State of Louisiana basis	$ 345,088,902	$ 279,634,856
State prescribed or permitted practices		
a. Furniture and equipment	(719,533)	(775,406)
Surplus – Codification	$ 344,369,369	$ 278,859,450

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL 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 (MA) 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 HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases the Company's effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021. The annual health insurance industry fee levied on the insurance industry was $15.5 billion in 2020.

The 2020 annual health insurance industry fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. A segregation was recorded within special surplus for the annual health insurance industry fee related to the 2019 data year for the 2020 fee. The 2020 health insurance industry fee was paid September 30, 2020. The impact of the annual health insurance industry fee on the Company's operations as of December 31, 2020 and 2019 were as follows:

	2020	2019
HCRL fee assessment payable	$ -	$ 44,204,567
HCRL fee assessment paid	41,987,405	-
Premium written subject to HCRL 9010 assessment	-	2,223,799,173
Total Adjusted Capital Level before surplus adjustment	345,088,902	279,634,856
Total Adjusted Capital Level after surplus adjustment	345,088,902	235,430,289
Authorized Control Level after surplus adjustment	73,617,376	65,262,954

It is reasonably possible that the HCRL and related regulations, as well as other current or future legislative, judicial or regulatory changes, such as the Families First Coronavirus Response Act (the "Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES

Act") and other legislative or regulatory action taken in response to COVID-19 including restrictions on Humana's ability to manage its provider network or otherwise operate its business, or restrictions on profitability, including reviews by regulatory bodies that may compare its MA profitability to its non-MA business profitability, or compare the profitability of various products within its MA business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, or increases in regulation of Humana's prescription drug benefit businesses, in the aggregate may have a material adverse effect on Humana's results of operations, (including restricting premiums, enrollment and premium growth in certain products and market segments, restricting Humana's ability to expand into new markets, increasing its medical and operating costs, further lowering its Medicare payment rates and increasing its expenses associated with assessments); its financial position; and its cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the HCRL or declare all or certain portions of the HCRL unconstitutional, create uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

c. **Cash, Cash Equivalents and Short-Term Investments:** The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Short-term investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. **Investments:** Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as the 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, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the

investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as the 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, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds, cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2020 or December 31, 2019.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2020 or 2019.

For other restricted assets reported in aggregate, the pledged amounts with the Department were $1,250,000 and $1,000,000, which is 0.18% and 0.19% of gross assets and 0.19% and 0.19% of net admitted assets, at December 31, 2020 and 2019, respectively. These investments, generally certificates of deposit, were on deposit at December 31, 2020 and 2019 to satisfy requirements of regulatory agencies. These assets are included in cash and bonds in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

e. Fair Value: In accordance with SSAP No. 100R, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2020 or 2019.

The Company did not have any financial assets carried at fair value in the accompanying statements of admitted assets, liabilities, and surplus as of December 31, 2020 and 2019.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2020 and 2019 were as follows:

	December 31, 2020					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and cash equivalents	$ 587,750,171	$ 571,147,799	$ 77,996,977	$ 509,753,194	$ -	$ -

	December 31, 2019					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 441,692,148	$ 432,527,575	$ 26,303,500	$ 415,388,648	$ -	$ -

f. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other income (expense) in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from 3 to 10 years. Depreciation expense, including that related to the nonadmitted portion, was $146,548 and $194,774 for the years ended December 31, 2020 and 2019, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements was $182,351 and $221,052 for the years ended December 31, 2020 and 2019, respectively.

g. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2020 and 2019 DTAs of $172,075 and $140,442, respectively, were nonadmitted.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

h. Earned Premiums: Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for its membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information 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. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022.

The amount of net premiums written by the Company in 2020 and 2019 that were subject to retrospective rating features were $2,505,288,743 and $2,196,056,462, respectively, or 97.01% and 97.57%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $23,096,271 and $30,255,445 as of December 31, 2020 and 2019, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company did not have any rebates incurred, paid or unpaid as of December 31, 2020 and 2019.

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

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as define by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the

contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2020 and 2019:

	2020		2019	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 3,403,311	$ -	$ 499,862	$ -
Amounts receivable relating to uninsured plans	-	11,293,207	-	8,444,091
Aggregate health policy reserves	(2,140,108)	-	(1,892,346)	-
Accounts payable and accrued expenses	-	(10,094,972)	-	(5,013,876)
Net asset (liability)	$ 1,263,203	$ 1,198,235	$ (1,392,484)	$ 3,430,215

j. Accounting for the Risk-Sharing Provisions of the Health Care Reform Law: Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health

insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company risk adjustment data for 2018 and 2019 was selected for audit by HHS. The final assessment from this audit was immaterial to the statutory statements of revenues and expenses.

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

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2020 and 2019:

HCRL Risk Adjustment		
Assets	**2020**	**2019**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 2,900,060	$ 310,364
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	16,485	24,225
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	-	154,529
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	1,985,298	(800,019)
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	13,821	22,532

HCRL Risk Corridor		
Assets	**2020**	**2019**
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	6,513,426	-
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 415,970	$ -	$ 415,970	$ -	$ -	$ -
2015	3,073,968	-	3,073,968	-	-	-
2016	3,092,926	-	3,092,926	-	-	-
Total	$ 6,582,864	$ -	$ 6,582,864	$ -	$ -	$ -

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal government for payments under the risk corridor premium stabilization program established under the HCRL for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, the Company received $6,513,426 from the U.S. Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $6,513,426 payment received from the U.S. Government and $325,573 in related fees and expenses are reflected in net premium income and selling, general and administrative expenses, respectively.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

A roll-forward of risk corridor assets, gross of any nonadmissions and liability balances by program year, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before Dec 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before Dec 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 -3)	Prior Year Accrued Less Payments (Col 2 -4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
Risk Corridors Program Year	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. 2014											
1. Accrued retrospective premium	-		346,532		(346,532)		346,532		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
b. 2015											
1. Accrued retrospective premium	-		3,073,968		(3,073,968)		3,073,968		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
c. 2016											
1. Accrued retrospective premium	-		3,092,926		(3,092,926)		3,092,926		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
d. Total for Risk Corridors	-	-	6,513,426	-	(6,513,426)	-	6,513,426	-		-	-

Explanations of adjustments

A. Adjustment recorded for additional risk corridor payments received in 2020 that had been previously written off.

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

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the transitional HCRL reinsurance program as of December 31, 2020 and 2019:

	2020	2019
Assets		
Amounts recoverable for claims paid due to HCRL Reinsurance	$ -	$ -
Amounts recoverable for claims unpaid due to HCRL Reinsurance (Contra Liability)	-	-
Amounts receivable relating to uninsured plans for contributions for HCRL Reinsurance	-	-
Liabilities		
Liabilities for contributions payable due to HCRL Reinsurance – not reported as ceded premium	-	-
Ceded reinsurance premiums payable due to HCRL Reinsurance	-	-
Liabilities for amounts held under uninsured plans contributions for HCRL Reinsurance	-	-
Operations (Revenues & Expenses)		
Ceded reinsurance premiums due to HCRL Reinsurance	-	-
Reinsurance recoveries (income statement) due to HCRL Reinsurance payments or expected payments	-	38,958
HCRL Reinsurance contributions – not reported as ceded premiums	-	-

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	310,364		216		310,148		2,458,368		A.	2,768,516	
2. Premium adjustments (payables) (including high risk pool payments)		(154,529)		(759,144)		604,615		(604,615)	B.		-
3. Subtotal ACA Permanent Risk Adjustment Program	310,364	(154,529)	216	(759,144)	310,148	604,615	2,458,368	(604,615)		2,768,516	-

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-		-		-		-			-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance-not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		6,513,426		(6,513,426)		6,513,426		C.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	6,513,426	-	(6,513,426)	-	6,513,426	-		-	-
d. Total for ACA Risk Sharing Provisions	310,364	(154,529)	6,513,642	(759,144)	(6,203,278)	604,615	8,971,794	(604,615)		2,768,516	-

Explanation for adjustments

A. Adjustments related to updates received from CMS associated with 2019 benefit year and the latest data from Wakely Consulting.

B. Small Group estimate changes for unfinalized years, based on latest data from Wakely Consulting.

C. Adjustment recorded for additional risk corridor payments received in 2020 that had been previously written off.

Net collections and payments under the 3Rs associated with prior coverage years were $5,754,498 and $(2,257,433) in 2020 and 2019, respectively.

k. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 8. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2020, 2019, and 2018:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days After Billing
12/31/2020	$ 38,575,173	$ 38,575,173	$ -	$ -	$ -
9/30/2020	51,140,722	51,140,722	50,802,132	-	-
6/30/2020	55,826,262	55,826,262	55,355,084	346,063	-
3/31/2020	44,038,822	44,038,822	43,108,835	883,660	26,776
12/31/2019	32,409,099	32,409,099	32,211,775	-	-
9/30/2019	37,222,346	37,222,346	36,963,112	72,501	186,733
6/30/2019	56,554,808	56,554,808	55,832,379	219,447	471,808
3/31/2019	39,411,645	39,411,645	39,018,971	-	392,674
12/31/2018	29,286,451	29,286,451	28,890,678	205,376	95,727
9/30/2018	35,112,475	35,112,475	34,969,900	142,575	-
6/30/2018	46,560,483	46,560,483	46,344,117	216,366	-
3/31/2018	32,699,931	32,699,931	32,699,931	-	-

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $806,424 and $1,104,438 were nonadmitted at December 31, 2020 and 2019, respectively.

I. **Benefits Incurred and Loss Adjustment Expenses:** Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $3,877,001 and $2,021,000 at December 31, 2020 and 2019, respectively, which are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

m. Nonadmitted Assets: Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

n. Going Concern Considerations: Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). Based on this evaluation, Management has determined that there is no substantial doubt about the Company's ability to continue as a going concern.

o. Reclassifications: Certain prior year amounts have been reclassified to conform to the 2020 financial statement presentation. These reclassifications have no impact on the Company's reported surplus, net income, or net cash flows.

p. Subsequent Events: The Company evaluated subsequent events through April 29, 2021, the date these financial statements were issued or available to be issued.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

On March 25, 2021, the Company requested to pay a dividend to its parent HIC of $100,000,000, of which, $65,500,000 was extraordinary. The Company received approval to pay the dividend from the Department on April 19, 2021. The Company has not yet paid the dividend.

The Company is not aware of any other events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements which may have a material effect on its financial condition.

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2020 and 2019 were as follows:

	2020			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 5,224,148	$ 280,716	$ -	$ 5,504,864
States, territories and possessions	103,208,147	3,255,090	(76,568)	106,386,669
Political subdivisions of states, territories and possessions	59,321,801	2,356,543	(2,058)	61,676,286
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	152,946,563	5,018,986	(96,151)	157,869,398
Industrial and miscellaneous	131,334,416	5,865,814	-	137,200,230
Hybrid Securities	-	-	-	-
Total bonds	$ 452,035,075	$ 16,777,149	$ (174,777)	$ 468,637,447

	2019			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 5,917,815	$ 114,078	$ (27,067)	$ 6,004,826
States, territories and possessions	73,422,668	2,447,292	(810)	75,869,150
Political subdivisions of states, territories and possessions	56,152,055	1,221,393	(58,447)	57,315,001
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	130,494,906	2,777,785	(192,874)	133,079,817
Industrial and miscellaneous	138,736,326	2,997,160	(113,937)	141,619,549
Hybrid Securities	-	-	-	-
Total bonds	$ 404,723,770	$ 9,557,708	$ (393,135)	$ 413,888,343

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2020, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 50,816,585	$ 51,177,250
Due after one year through five years	186,280,459	194,684,397
Due after five years through ten years	122,804,652	125,264,726
Due after ten years	61,663,132	64,019,614
Mortgage and asset-backed securities	30,470,248	33,491,460
	$ 452,035,075	$ 468,637,447

The detail of realized gains (losses) of bonds for the years ended December 31, 2020 and 2019 were as follows:

	2020	2019
Gross realized gains	$ 263,816	$ 260,773
Gross realized losses	(58,284)	(83,852)
Net realized gains	$ 205,532	$ 176,921

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2020 and 2019 were as follows:

	2020					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ -	$ -	$ -	$ -
States, territories and possessions	14,231,989	(76,568)	-	-	14,231,989	(76,568)
Political subdivisions of states, territories and possessions	1,195,654	(2,058)	-	-	1,195,654	(2,058)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	23,533,732	(96,151)	-	-	23,533,732	(96,151)
Industrial and misc.	-	-	-	-	-	-
Total invested assets	$ 38,961,375	$ (174,777)	$ -	$ -	$ 38,961,375	$ (174,777)

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

	2019					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ 2,091,701	$ (27,067)	$ 2,091,701	$ (27,067)
States, territories and possessions	-	-	487,227	(810)	487,227	(810)
Political subdivisions of states, territories and possessions	2,889,067	(56,292)	2,377,163	(2,155)	5,266,230	(58,447)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	9,828,982	(81,419)	19,627,549	(111,455)	29,456,531	(192,874)
Industrial and misc.	-	-	20,896,697	(113,937)	20,896,697	(113,937)
Total invested assets	$ 12,718,049	$ (137,711)	$ 45,480,337	$ (255,424)	$ 58,198,386	$ (393,135)

The unrealized loss from all debt securities was generated from 16 investment positions at December 31, 2020. All issuers of debt securities the Company owns that were trading at an unrealized loss at December 31, 2020 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2020, the Company did not intend to sell any debt securities with an unrealized loss position, and it is not likely that the Company will be required to sell these debt securities before recovery of their amortized cost basis. As a result, the Company believes that the debt securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2020.

Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2020 and 2019 were as follows:

	2020		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 6,584,820	$ -	$ 6,584,820
Statutory valuation allowance adjustment	-	-	-
Adjusted gross deferred tax assets	6,584,820	-	6,584,820
Deferred tax assets nonadmitted	(172,075)	-	(172,075)
Subtotal net admitted deferred tax assets	6,412,745	-	6,412,745
Gross deferred tax liabilities	(188,769)	-	(188,769)
Net admitted deferred tax asset/(liability)	$ 6,223,976	$ -	$ 6,223,976

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

	2019		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 4,595,881	$ -	$ 4,595,881
Statutory valuation allowance adjustment	-	-	-
Adjusted gross deferred tax assets	4,595,881	-	4,595,881
Deferred tax assets nonadmitted	(140,442)	-	(140,442)
Subtotal net admitted deferred tax assets	4,455,439	-	4,455,439
Gross deferred tax liabilities	(209,744)	-	(209,744)
Net admitted deferred tax asset/(liability)	$ 4,245,695	$ -	$ 4,245,695

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2020 and 2019 were as follows:

	December 31, 2020		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 6,072,260	$ -	$ 6,072,260
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	151,716	-	151,716
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	151,716
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	50,818,910
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	188,769	-	188,769
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 6,412,745	$ -	$ 6,412,745

	December 31, 2019		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 4,186,108	$ -	$ 4,186,108
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	59,587	-	59,587
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	59,587
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	41,308,374
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	209,744	-	209,744
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 4,455,439	$ -	$ 4,455,439

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2020	2019
Ratio percentage used to determine recovery period and threshold limitation amount	460%	422%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 338,792,733	$ 275,389,161

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2020 and 2019 consisted of the following:

	2020	2019
Current year income tax provision	$ 36,707,753	$ 20,634,286
Revisions in prior years' estimated taxes	1,861	(31,003)
Federal income tax expense excluding the tax on realized capital (losses) gains and before change in net deferred income taxes	36,709,614	20,603,283
Tax on realized capital (losses) gains	458,917	37,154
Change in net deferred income taxes	(2,009,914)	(1,202,134)
Total statutory income taxes	$ 35,158,617	$ 19,438,303

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2020 and 2019 were as follows:

	2020	2019	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 3,829,727	$ 3,188,518	$ 641,209
Advance premiums	286,112	212,465	73,647
Policyholder reserves	-	-	-
Investments	-	-	-
Deferred acquisition costs	300,071	251,320	48,751
Policyholder dividends accrual	-	-	-
Fixed assets	213,522	243,601	(30,079)
Compensation and benefit accruals	-	-	-
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	-	-	-
Bad debts	1,137,360	63,723	1,073,637
Accrued litigation	-	-	-
CMS Rx reserves	626,165	306,097	320,068
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	172,311	296,132	(123,821)
Accrued lease	-	4,696	(4,696)
Section 197 intangibles	19,552	29,329	(9,777)
Reinsurance fee	-	-	-
Provider contracts	-	-	-
Premium acquisition expense	-	-	-
Gross ordinary DTAs	6,584,820	4,595,881	1,988,939
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(172,075)	(140,442)	(31,633)
Admitted ordinary DTAs	6,412,745	4,455,439	1,957,306
Capital			
Investments	-	-	-
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	-	-	-
Statutory valuation allowance adjustment	-	-	-
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 6,412,745	$ 4,455,439	$ 1,957,306

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	-	-	-
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(3,916)	(5,777)	1,861
CMS Rx reserve	-	-	-
Reserve transition adjustment	(169,973)	(203,967)	33,994
Accrued lease	(14,880)	-	(14,880)
Ordinary DTLs	(188,769)	(209,744)	20,975
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(188,769)	(209,744)	20,975
Net deferred tax assets/(liabilities)	$ 6,223,976	$ 4,245,695	$ 1,978,281

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from.

The change in nonadmitted deferred tax assets from December 31, 2019 to 2020 was an increase of $31,633. The change in nonadmitted deferred tax assets from December 31, 2018 to 2019 was an increase of $60,612.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the HCRL fee, change to nonadmitted assets and deferred tax true-ups and tax-exempt interest in 2020.

The Company had no net operating loss carryforwards at December 31, 2020 or 2019.

The following table demonstrates the income tax expense for 2019 and 2020 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2019	$ 20,636,147	$ 37,154	$ 20,673,301
2020	36,707,753	458,917	37,166,670
	$ 57,343,900	$ 496,071	$ 57,839,971

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2020 or 2019.

As of December 31, 2020, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana's consolidated income tax returns for 2017 and prior years. Humana's 2018 and 2019 tax returns are in the post-filing review period under the Compliance Assurance Process (CAP). Humana's 2020 tax return is under advance review by the IRS under CAP. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2020 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2020
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	ARCADIAN HEALTH PLAN, INC.	20-1001348
6	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
7	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
8	CARENETWORK, INC.	39-1514846
9	CAREPLUS HEALTH PLANS, INC.	59-2598550
10	CARITEN HEALTH PLAN INC.	62-1579044
11	CHA HMO, INC.	61-1279717
12	COMPBENEFITS COMPANY	59-2531815
13	COMPBENEFITS CORPORATION	04-3185995
14	COMPBENEFITS DENTAL, INC.	36-3686002

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

15	COMPBENEFITS DIRECT, INC.	58-2228851
16	COMPBENEFITS INSURANCE COMPANY	74-2552026
17	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
18	CONTINUCARE CORPORATION	59-2716023
19	CONTINUCARE MEDICAL MANAGEMENT, INC.	65-0791417
20	CONVIVA HEALTH MANAGEMENT, LLC (f/k/a TRANSCEND POPULATION HEALTH MANAGEMENT, LLC)	46-5329373
21	CONVIVA HEALTH MSO OF TEXAS, INC. (f/k/a PRIMARY CARE HOLDINGS, INC.)	46-1225873
22	CONVIVA MEDICAL CENTER MANAGEMENT OF TEXAS, P.A. (f/k/a PARTNERS IN PRIMARY CARE, P.A.)	47-1161014
23	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
24	DENTICARE, INC.	76-0039628
25	EAGLE RX HOLDCO, INC.	47-1407967
26	EAGLE RX, INC.	47-1416614
27	EDGE HEALTH MSO, INC.	84-2214810
28	EDGE HEALTH, P.C.	84-2752906
29	EMPHESYS INSURANCE COMPANY	31-0935772
30	EMPHESYS, INC.	61-1237697
31	ENCLARA PHARMACIA, INC.	23-3068914
32	FAMILY PHYSICIANS OF WINTER PARK, INC.	59-3164234
33	FPG ACQUISITION CORP.	81-3802918
34	FPG ACQUISITION HOLDINGS CORP.	81-3819187
35	FPG HOLDING COMPANY, LLC	32-0505460
36	GUIDANTRX, INC.	39-1789830
37	HARRIS, ROTHENBERG INTERNATIONAL, INC.	27-1649291
38	HEALTH VALUE MANAGEMENT, INC.	61-1223418
39	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
40	HUMANA AT HOME (DALLAS), INC.	75-2739333
41	HUMANA AT HOME (HOUSTON), INC.	76-0537878
42	HUMANA AT HOME (SAN ANTONIO), INC.	01-0766084
43	HUMANA AT HOME (TLC), INC.	75-2600512
44	HUMANA AT HOME 1, INC.	65-0274594
45	HUMANA AT HOME, INC.	13-4036798
46	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
47	HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.	84-3226630
48	HUMANA BENEFIT PLAN OF TEXAS, INC.	75-2043865
49	HUMANA DENTAL COMPANY	59-1843760
50	HUMANA DIGITAL HEALTH AND ANALYTICS PLATFORM SERVICES, INC.	80-0072760
51	HUMANA DIRECT CONTRACTING ENTITY, INC.	85-3099097
52	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
53	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
54	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
55	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
56	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
57	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
58	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
59	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
60	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

61	HUMANA HEALTH PLAN, INC.	61-1013183
62	HUMANA HEALTHCARE RESEARCH, INC.	42-1575099
63	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
64	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
65	HUMANA INSURANCE COMPANY	39-1263473
66	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
67	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
68	HUMANA MARKETPOINT, INC.	61-1343508
69	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
70	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
71	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
72	HUMANA MEDICAL PLAN, INC.	61-1103898
73	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
74	HUMANA PHARMACY, INC.	61-1316926
75	HUMANA REAL ESTATE COMPANY	20-1724127
76	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
77	HUMANA VETERANS HEALTHCARE SERVICES, INC.	20-8418853
78	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
79	HUMANADENTAL INSURANCE COMPANY	39-0714280
80	HUMANADENTAL, INC.	61-1364005
81	HUMCO, INC.	61-1239538
82	HUM-e-FL, INC.	61-1383567
83	MANAGED CARE INDEMNITY, INC.	61-1232669
84	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
85	METCARE OF FLORIDA, INC.	65-0879131
86	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
87	PARTNERS IN INTEGRATED CARE, INC.	47-2905609
88	PARTNERS IN PRIMARY CARE (GA), P.C.	83-2624178
89	PARTNERS IN PRIMARY CARE (KS), P.A.	30-1236218
90	PARTNERS IN PRIMARY CARE (KS), P.C.	85-0733589
91	PARTNERS IN PRIMARY CARE (MO), P.C.	85-3676937
92	PARTNERS IN PRIMARY CARE (NC), P.C.	82-1926920
93	PARTNERS IN PRIMARY CARE (SC), P.C.	85-3577914
94	PBM HOLDING COMPANY	61-1340806
95	PBM PLUS MAIL SERVICE PHARMACY, LLC	20-2373204
96	PHP COMPANIES, INC.	62-1552091
97	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
98	PRIMARY CARE MANAGEMENT, INC.	85-0858631
99	ROHC, LLC	75-2844854
100	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
101	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
102	TEXAS DENTAL PLANS, INC.	74-2352809
103	THE DENTAL CONCERN, INC.	52-1157181
104	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
105	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
106	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

5. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2020 and 2019 are summarized as follows:

	2020	2019
Balance at January 1,	$ 210,151,227	$ 171,420,855
Health care receivables	(32,724,392)	(30,815,294)
Balance at January 1, net of health care receivables	177,426,835	140,605,561
Benefits incurred and loss adjustment expenses related to		
Current year	2,181,165,902	1,972,934,198
Prior year	(7,552,606)	(5,600,158)
	2,173,613,296	1,967,334,040
Benefits and loss adjustment expenses paid related to		
Current year	1,943,940,496	1,800,742,299
Prior year	168,134,948	129,770,467
	2,112,075,444	1,930,512,766
Balance at December 31,	282,873,684	210,151,227
Health care receivables	(43,908,997)	(32,724,392)
Balance at December 31, net of health care receivables	$ 238,964,687	$ 177,426,835

Benefits and loss adjustment expenses payable, net of healthcare receivables, as of December 31, 2019 were $177,426,835. As of December 31, 2020, $168,134,948 has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $1,739,281 as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been a $7,552,606 favorable prior-year development since December 31, 2019. The decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Included in this decrease, the Company experienced $14,539,521 of favorable prior year claim development on retrospectively rated policies. However, the business to which it relates is subject to premium adjustments.

6. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the Department statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the Department is the lesser of 10% of total surplus, or the greater of net operating gain for the calendar year preceding the dividend or for the 3 calendar years preceding the dividend less dividends paid for the most recent 2 of those calendar years. All ordinary dividends are limited to available and accumulated surplus funds. Based on these restrictions, the Company could have paid a maximum dividend or return of capital to shareholders of approximately $27,960,000 in 2020 without prior regulatory approval.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. Extraordinary amounts have been approved by the Department.

		Dividend or Return of Capital Amount		
		Ordinary	Extraordinary	Date Paid
Dividend		$ 27,500,000	$ -	May 26, 2020
	Total paid in 2020	$ 27,500,000	$ -	
Dividend		$ 25,280,000	$ 24,720,000	April 30, 2019
	Total paid in 2019	$ 25,280,000	$ 24,720,000	

7. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Louisiana has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $73,617,376 or the Company, under the discretion of the Commissioner of the Department, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Louisiana which require a minimum capital and surplus level of $147,234,752 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $345,088,902 and $279,634,856 as of December 31, 2020 and 2019, respectively.

8. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $185,997 and $264,508 for the years ended December 31, 2020 and 2019, respectively.

Employees supporting the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2020 and 2019 total allocated expenses associated with these plans were $3,104,018 and $2,379,744, respectively, and are included in the management fee noted below.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2020 and 2019 were $274,700,933 and $222,278,616, respectively, which are recorded as a charge to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 4, which were $47,929,458 and $23,875,644 for the years ended December 31, 2020 and 2019, respectively. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $8,188,052 and $16,197,204 due from Humana at December 31, 2020 and 2019, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

In the ordinary course of business, the Company also directly contracts with related parties to provide services that are routine in nature to its members. The administrative services, access fees, and cost of care services provided are determined within each individual agreement. These amounts are included in benefits incurred and loss adjustment expenses as well as selling, general and administrative expenses in the statutory statements of revenue and expenses.

The following table identifies the amount for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2020 and 2019, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliate and Other Related Parties* (SSAP No. 25):

		2020	2019
SeniorBridge and Humana At Home	$	20,500,557	$ 18,409,488
PMR Virginia Holding LLC (JenCare)		32,755,157	-
Total	$	53,255,714	$ 18,409,488

In addition to the related parties above, the Company also has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(k) for further consideration of related pharmacy rebates. The Company had $713,336,737 and $588,521,643 of administrative service and prescription costs in 2020 and 2019, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(i).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $224,577,725 and $180,810,672 of prescription costs in 2020 and 2019, respectively, with Humana Pharmacy, Inc.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The Company received no capital contributions in the years ended December 31, 2020 or 2019.

Humana forgave $640,194 of the Company's tax liability due to Humana as part of the Company's tax sharing agreement during 2019. The portion of the tax balance being forgiven is associated with an issue that was previously subject to IRS Appeals. The forgiveness was accounted for as contributed surplus per SSAP No. 72 *Surplus and Quasi-Reorganizations* (SSAP No. 72).

9. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to four years. Operating lease rental payments charged to expenses for the years ended December 31, 2020 and 2019 was $1,502,726 and $1,437,327, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

Future minimum rental payments required under operating leases as of December 31, 2020, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2021	$	1,283,357
2022		1,101,548
2023		1,112,675
2024		1,112,675
2025		-
Thereafter		-
Total minimum lease payments	$	4,610,255

10. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $2,214,734,297 and $1,891,053,121 for the years ended December 31, 2020 and 2019, respectively. The loss of the Contracts (which are generally renewed annually) or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2021, and all product offerings filed with CMS for 2021 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the BBA and BIPA, generally, pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers

and submit the necessary diagnosis code information 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. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, the Company conducts medical record reviews as part of its data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below as well as ordinary course reviews of the Company's internal business processes.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the RAPS to diagnoses data from the EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on the Company's results of statutory statements of revenue and expenses, changes in surplus or cash flows.

CMS and the Office of the Inspector General of Health and Human Services (HHS-OIG) are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation (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 RADV Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of the government's traditional fee-for-service Medicare program, or Medicare FFS. The Company refers to the process of accounting for errors in FFS claims as the FFS Adjuster. This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for the payment years 2015 and 2014. CMS completed its RADV contract level audit of the 2012 payment year, but has not yet provided the results.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2016. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana believes that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and has provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus or cash flows.

Humana believes that, CMS's statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS's 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS's final rule release regarding MA and Part D prescription drug benefit program regulations for Contract Year 2015 (referred to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each MA risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

The Company 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 the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

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

b. **COVID-19:** The emergence and spread of the novel coronavirus, or COVID-19, has impacted the Company's business. Beginning in the second half of March 2020, the implementation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity resulted in the temporary deferral of non-essential care and significant reduction in hospital admissions and overall healthcare system utilization during April 2020. Non-COVID utilization then began to increase during May and June 2020 and continued to rebound throughout the third quarter and early in the fourth quarter of 2020. Then, in the latter half of November and accelerating throughout the month of December, the Company experienced a significant increase in COVID-19 admissions in nearly all of the markets in which it operates across the Company's lines of business resulting in higher COVID-19 treatment and testing costs. During this period, the Company also experienced a corresponding decline in non-COVID utilization in all service categories. The impact of this decline in non-COVID utilization more than offset the higher COVID-19 treatment and testing costs during the period. The Company's 2020 results were also impacted by ongoing pandemic relief efforts.

c. **Legal Proceedings:** During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus and cash flows, and may also affect the Company's reputation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided Humana's legal counsel with an information request concerning Humana's Medicare Part C risk adjustment practices. The request relates to Humana's oversight and submission of risk adjustment data generated by providers in its MA network, as well as to its business and compliance practices related to risk adjustment data generated by its providers and by Humana, including medical record reviews conducted as part of its data and payment accuracy compliance

efforts, the use of health and well-being assessments, and fraud detection efforts. Humana believes that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of MA plans, providers and vendors. Humana continues to cooperate with the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned *United States of America ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by Humana in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by it under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. Humana takes seriously its obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations since the transfer to the Western District of Kentucky. Humana has substantially completed discovery with the relator who has pursued the matter on behalf of the United States following its unsealing, and expects the Court to consider its motion for summary judgment.

d. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

e. Securities & Credit Markets Risks: Ongoing volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or credit related impairments may be recorded in future periods.

Supplemental Investment Information

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

Of the **Humana Health Benefit Plan of Louisiana, Inc.** Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436

NAIC Group Code 0119 NAIC Company Code 95642 Employer's ID Number 72-1279235

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 3 of the statement of admitted assets, liabilities and surplus. $674,252,399.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	State Of Louisiana	Municipal	$ 123,803,713	18.36%
2.02	Federal Farm Credit Banks Funding Corporation	Bonds	30,489,107	4.52%
2.03	Federal National Mortgage Association	MBS CMO	23,928,633	3.55%
2.04	Federal Home Loan Banks	Bonds	22,855,000	3.39%
2.05	Apple Inc.	Bonds Commercial Paper	14,504,161	2.15%
2.06	Bossier Parish Schools	Municipal	14,424,241	2.14%
2.07	City of New Orleans	Municipal	14,228,277	2.11%
2.08	East Baton Rouge Louisiana Sewerage Commission	Municipal	10,810,408	1.60%
2.09	Shreveport Louisiana	Municipal	9,863,474	1.46%
2.10	Entergy Louisiana LLC	Bonds	8,826,151	1.31%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 477,811,242	70.87%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	48,714,062	7.22%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	1,506,984	0.22%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	1,999,763	0.30%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	-	0.00%	3.12	P/RP-6	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?		Yes [X]	No [ ]
4.02	Total admitted assets held in foreign investments.	$	-	0.00%
4.03	Foreign-currency-denominated investments.		-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency		-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	-	0.00%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
6.01	Country:	$	-	0.00%
6.02	Country:		-	0.00%
	Countries rated NAIC - 2			
6.03	Country:	$	-	0.00%
6.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
6.05	Country:	$	-	0.00%
6.06	Country:		-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1 Issuer	2 NAIC Rating	3	4
10.01			$ -	0.00%
10.02			-	0.00%
10.03			-	0.00%
10.04			-	0.00%
10.05			-	0.00%
10.06			-	0.00%
10.07			-	0.00%
10.08			-	0.00%
10.09			-	0.00%
10.10			-	0.00%

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.			
11.02	Total admitted assets held in Canadian Investments	$	-	0.00%
11.03	Canadian-currency-denominated investments		-	0.00%
11.04	Canadian-denominated insurance liabilities		-	0.00%
11.05	Unhedged Canadian currency exposure		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ -	0.00%
	Largest 3 investments with contractual sales restrictions		
12.03		-	0.00%
12.04		-	0.00%
12.05		-	0.00%

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

	1	2	3
	Name of Issuer		
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06	JPMorgan Trust II - JPMorgan U.S. Treasury Plus Money Market Fund	$ 41,115,747	$ 41,115,747	$ -
14.07		-	-	-
14.08		-	-	-
14.09		-	-	-
14.10		-	-	-
14.11		-	-	-
14.12		-	-	-
14.13		-	-	-
14.14		-	-	-
14.15		-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1	2	3
	Type (Residential, Commercial, Agricultural)		
16.02		$ -	0.00%
16.03		-	0.00%
16.04		-	0.00%
16.05		-	0.00%
16.06		-	0.00%
16.07		-	0.00%
16.08		-	0.00%
16.09		-	0.00%
16.10		-	0.00%
16.11		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description		
	1	2	3
18.02		$ -	0.00%
18.03		-	0.00%
18.04		-	0.00%
18.05		-	0.00%
18.06		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:	**2**	**3**
		$ -	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description **1**	**2**	**3**
19.03	-	$ -	0.00%
19.04	-	-	0.00%
19.05	-	-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2020

		Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
		1 Amount	2 Percentage	1 Amount	2 Percentage
1. Long-Term Bonds					
1.01	U.S. governments	$ 5,224,149	0.91%	$ 5,224,149	0.91%
1.02	All other governments	-	0.00%	-	0.00%
1.03	U.S. states, territories and possessions, etc. guaranteed	103,208,147	18.07%	103,208,147	18.07%
1.04	U.S. political subdivisions of states, territories, and possessions, guaranteed	59,321,801	10.38%	59,321,801	10.38%
1.05	U.S. special revenue and special assessment obligations, etc. non-guaranteed	152,946,563	26.77%	152,946,563	26.77%
1.06	Industrial and miscellaneous	131,334,416	22.99%	131,334,416	22.99%
1.07	Hybrid securities	-	0.00%	-	0.00%
1.08	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
1.09	SVO identified funds	-	0.00%	-	0.00%
1.10	Unaffiliated Bank loans	-	0.00%	-	0.00%
1.11	Total long-term bonds	452,035,075	79.13%	452,035,075	79.13%
2. Preferred stocks					
2.01	Industrial and miscellaneous (Unaffiliated)	-	0.00%	-	0.00%
2.02	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
2.03	Total preferred stocks	-	0.00%	-	0.00%
3. Common stocks					
3.01	Industrial and miscellaneous Publicly traded (Unaffiliated)	-	0.00%	-	0.00%
3.02	Industrial and miscellaneous Other (Unaffiliated)	-	0.00%	-	0.00%
3.03	Parent, subsidiaries and affiliates Publicly traded	-	0.00%	-	0.00%
3.04	Parent, subsidiaries and affiliates Other	-	0.00%	-	0.00%
3.05	Mutual funds	-	0.00%	-	0.00%
3.06	Unit investment trusts	-	0.00%	-	0.00%
3.07	Closed-end funds	-	0.00%	-	0.00%
3.08	Total common stocks	-	0.00%	-	0.00%
4. Mortgage loans					
4.01	Farm mortgages	-	0.00%	-	0.00%
4.02	Residential mortgages	-	0.00%	-	0.00%
4.03	Commercial mortgages	-	0.00%	-	0.00%
4.04	Mezzanine real estate loans	-	0.00%	-	0.00%
4.05	Total valuation allowance	-	0.00%	-	0.00%
4.06	Total mortgage loans	-	0.00%	-	0.00%
5. Real estate					
5.01	Properties occupied by company	-	0.00%	-	0.00%
5.02	Properties held for production of income	-	0.00%	-	0.00%
5.03	Properties held for sale	-	0.00%	-	0.00%
5.04	Total real estate	-	0.00%	-	0.00%
6. Cash, cash equivalents and short-term investments					
6.01	Cash	69,140	0.01%	69,140	0.01%
6.02	Cash equivalents	119,112,724	20.85%	119,112,724	20.85%
6.03	Short-term investments	-	0.00%	-	0.00%
6.04	Total cash, cash equivalents and short-term investments	119,181,864	20.86%	119,181,864	20.86%
7. Contract loans		-	0.00%	-	0.00%
8. Derivatives		-	0.00%	-	0.00%
9. Other invested assets		-	0.00%	-	0.00%
10. Receivables for securities		16,750	0.00%	16,750	0.00%
11. Securities Lending		-	0.00%	-	0.00%
12. Other invested assets		-	0.00%	-	0.00%
13.	Total invested assets	$ 571,233,689	100.00%	$ 571,233,689	100.00%

Humana Health Benefit Plan of Louisiana, Inc.

(a wholly owned subsidiary of Humana Insurance Company, a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2019 and 2018

Humana Health Benefit Plan of Louisiana, Inc.
Index
Statutory Basis of Accounting
December 31, 2019 and 2018

Page

Report of Independent Auditors 1

Financial Statements

Statements of Admitted Assets, Liabilities and Surplus 3

Statements of Revenue and Expenses 4

Statements of Changes in Surplus 5

Statements of Cash Flows 6

Notes to Financial Statements 7

Supplemental Investment Information

Investment Risk Interrogatories 42

Summary Investment Schedule 51

Report of Independent Auditors

To the Board of Directors of Humana Health Benefit Plan of Louisiana, Inc.

We have audited the accompanying statutory financial statements of Humana Health Benefit Plan of Louisiana, Inc., which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2019 and 2018, and the related statutory statements of revenue and expenses and changes in surplus, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

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Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2019 and 2018, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2019 and 2018, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana described in Note 2.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the financial statements taken as a whole. The supplemental investment risk interrogatories and summary investment schedule (collectively, the "supplemental schedules") of the Company, as of December 31, 2019 and for the year then ended, are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and is not a required part of the financial statements. The information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 30, 2020

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2019 and 2018

	2019	2018
Admitted Assets		
Cash and invested assets		
Bonds	$ 404,723,770	$ 441,519,287
Receivable for securities	5,431	-
Short-term investments	1,500,305	2,116,963
Total invested assets	406,229,506	443,636,250
Cash and cash equivalents	23,302,585	(4,639,916)
Total cash and invested assets	429,532,091	438,996,334
Premiums receivable	33,027,843	22,811,704
Investment income due and accrued	3,954,602	4,563,864
Amounts receivable relating to uninsured plans	8,444,091	2,117,881
Health care and other receivables	34,840,491	30,485,392
Current federal income tax recoverable	-	1,005,665
Net deferred tax assets	4,245,695	3,104,173
Furniture and equipment, less accumulated depreciation of $701,078 and $1,050,006 in 2019 and 2018, respectively	775,406	1,209,176
Receivable from Humana, Inc.	16,197,204	-
Total admitted assets	$ 531,017,423	$ 504,294,189
Liabilities		
Benefits and loss adjustment expenses payable	$ 210,151,227	$ 171,420,855
Aggregate health policy reserves	20,481,174	17,668,913
Aggregate health claim reserves	142,000	558,000
Advance premiums	5,084,272	6,481,459
Accounts payable and accrued expenses	12,104,169	11,899,954
Current federal income tax payable	3,419,725	-
Payable to Humana, Inc.	-	43,398,493
Total liabilities	251,382,567	251,427,674
Surplus		
Common stock, $0 par value; $1 per share stated value; 1,000 shares authorized; 1,000 shares issued and outstanding	1,000	1,000
Special surplus - projected HCRL fee assessment	44,204,567	-
Paid-in surplus	66,400,346	65,760,152
Unassigned surplus	169,028,943	187,105,363
Total surplus	279,634,856	252,866,515
Total liabilities and surplus	$ 531,017,423	$ 504,294,189

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2019 and 2018

	2019	2018
Earned premiums	$ 2,250,677,753	$ 2,000,006,063
Expenses		
Benefits incurred and loss adjustment expenses	1,967,334,040	1,737,762,000
Selling, general and administrative expenses	199,602,237	221,383,809
Changes in aggregate health policy reserves	1,605,000	(4,377,075)
Total expenses	2,168,541,277	1,954,768,734
Net underwriting gain	82,136,476	45,237,329
Net investment income	13,201,421	13,415,748
Net realized capital gains (losses) on investments (net of capital gains tax of $37,154 and $(7,157), respectively)	139,768	(26,924)
Net other (expense) income	(239,814)	86,042
Income before federal income tax expense	95,237,851	58,712,195
Federal income tax expense	20,603,283	13,535,350
Net income	$ 74,634,568	$ 45,176,845

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2019 and 2018

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2018	1,000	$ 1,000	$ 41,411,031	$ 65,993,254	$ 186,880,836	$ 294,286,121
Net income	-	-	-	-	45,176,845	45,176,845
HCRL fee moratorium	-	-	(41,411,031)	-	41,411,031	-
Change in net unrealized capital loss, less capital gains tax of $0	-	-	-	-	(148,313)	(148,313)
Change in net deferred income taxes	-	-	-	-	(4,740,495)	(4,740,495)
Change in nonadmitted assets	-	-	-	-	525,459	525,459
Other	-	-	-	(233,102)	-	(233,102)
Dividends or return of capital paid	-	-	-	-	(82,000,000)	(82,000,000)
Balances at December 31, 2018	1,000	1,000	-	65,760,152	187,105,363	252,866,515
Net income	-	-	-	-	74,634,568	74,634,568
Projected HCRL fee assessment	-	-	44,204,567	-	(44,204,567)	-
Change in net unrealized capital gain, less capital gains tax of $0	-	-	-	-	148,313	148,313
Change in net deferred income taxes	-	-	-	-	1,202,134	1,202,134
Change in nonadmitted assets	-	-	-	-	143,132	143,132
Forgiveness of payable from Humana Inc.	-	-	-	640,194	-	640,194
Dividends or return of capital paid	-	-	-	-	(50,000,000)	(50,000,000)
Balances at December 31, 2019	1,000	$ 1,000	$ 44,204,567	$ 66,400,346	$ 169,028,943	$ 279,634,856

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2019 and 2018

	2019	2018
Cash flows from operations		
Premiums collected	$ 2,239,951,121	$ 1,951,079,414
Net investment income received	17,322,837	16,818,041
Benefits paid	(1,854,576,373)	(1,690,941,575)
Selling, general and administrative expenses paid	(283,011,596)	(307,647,364)
Federal income taxes paid	(15,744,914)	(19,525,505)
Net cash from (used for) operations	103,941,075	(50,216,989)
Cash flows from investments		
Proceeds from investments sold or matured	93,515,823	54,455,459
Cost of investments acquired	(59,912,657)	(74,127,686)
Net cash from (used for) investments	33,603,166	(19,672,227)
Cash flows from financing and miscellaneous sources		
Dividends or returns of capital paid	(50,000,000)	(82,000,000)
Other cash (applied) provided	(60,218,398)	49,885,712
Net cash used for financing and miscellaneous sources	(110,218,398)	(32,114,288)
Net change in cash, cash equivalents and short-term investments	27,325,843	(102,003,504)
Cash, cash equivalents and short-term investments		
Beginning of year	(2,522,953)	99,480,551
End of year	$ 24,802,890	$ (2,522,953)

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

1. Reporting Entity

Humana Health Benefit Plan of Louisiana, Inc. (the Company), a wholly owned subsidiary of Humana Insurance Company (HIC), a wholly owned subsidiary of CareNetwork, Inc. (CNI), a wholly owned subsidiary of Humana Inc. (Humana), is a health maintenance organization (HMO) domiciled in the state of Louisiana and is authorized to sell health plan products therein. The Company is subject to regulation by the federal government and the Louisiana Department of Insurance (the Department). State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 7, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 6.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 10(a).

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

On August 5, 2019, Humana was notified by the Louisiana Department of Health of their intent to award Humana a statewide contract for their 2020 Medicaid Managed Care program, which two of the current contract holders protested. As a result of the protest, the Louisiana Department of Health decided to re-bid the Medicaid contract. Humana has submitted an appeal of the decision to do a complete re-bid and as of the date these financial statements were issued, that decision is pending.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately materially differ from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the Department, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(n), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Comprehensive income disclosures required by GAAP are omitted; and

viii. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

ix. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The Department adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The Department has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. The Commissioner of Insurance of the State of Louisiana allows the Company to admit its furniture and equipment used for Health Maintenance Organization operations, which is not in accordance with NAIC SSAP. The omission of this prescribed practice would have had no impact to the results of the Company's risk-based capital calculations.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The statutory financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department. A reconciliation of the Company's net income and surplus based on practices prescribed by the Department to net income and surplus based on Codification at December 31, 2019 and 2018 is shown below:

	2019	2018
Net Income – State of Louisiana basis	$ 74,634,568	$ 45,176,845
State prescribed or permitted practices	-	-
Net Income – Codification	$ 74,634,568	$ 45,176,845
Surplus – State of Louisiana basis	$ 279,634,856	$ 252,866,515
State prescribed or permitted practices		
a. Furniture and equipment	(775,406)	(1,209,176)
Surplus – Codification	$ 278,859,450	$ 251,657,339

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL 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 (MA) 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 HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee was suspended in 2019, but will resume for calendar year 2020, not be deductible for income tax purposes, and significantly increase the Company's effective tax rate. The annual health insurance industry fee levied on the insurance industry was $14.3 billion in 2018. Under current law, the health industry fee will be permanently repealed beginning in calendar year 2021.

It is reasonably possible that the HCRL and related regulations, as well as other current or future legislative, judicial or regulatory changes, including restrictions on Humana's ability to manage its provider network or otherwise operate its business, or restrictions on profitability, including reviews by regulatory bodies that may compare its MA profitability to its non-MA business profitability, or compare the profitability of various products within its MA business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, or increases in regulation of Humana's prescription drug benefit businesses, in the aggregate may have a material adverse effect on Humana's results of operations, (including restricting premiums, enrollment and premium growth in certain products and market segments, restricting Humana's ability to expand into new markets, increasing its medical and operating costs, further lowering its Medicare payment rates and increasing its expenses associated with assessments); its financial position; and its cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the HCRL or declare all or certain portions of the HCRL unconstitutional, creates uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

c. Cash, Cash Equivalents and Short-Term Investments: The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Short-term investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. Investments: Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as 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, changes in fair value of the security after the balance sheet date, and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as 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, changes in fair value of the security after the balance sheet date, and cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2019 or December 31, 2018.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2019 or 2018.

For other restricted assets reported in aggregate, the pledged amounts with the Department were $1,000,000 and $1,000,000, which is 0.19% and 0.20% of gross assets and 0.19% and 0.20% of net admitted assets, at December 31, 2019 and 2018, respectively.

e. Fair Value: In accordance with SSAP No. 100, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less

frequently, an income valuation approach and are generally classified as Level 2. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2019 or 2018.

There were no financial assets carried at fair value at December 31, 2019. The fair value of financial assets carried at fair value at December 31, 2018 were as follows:

	Fair Value Measurements at December 31, 2018			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Corporate debt securities	-	3,367,500	-	3,367,500
Total invested assets	$ -	$ 3,367,500	$ -	$ 3,367,500

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2019 and 2018 were as follows:

	December 31, 2019					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 441,692,148	$ 432,527,575	$ 26,303,500	$ 415,388,648	$ -	$ -

	December 31, 2018					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and short-term investments	$ 441,448,042	$ 443,636,250	$ -	$ 441,448,042	$ -	$ -

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The Company reports transfers between fair value hierarchy levels at the end of the reporting period. There were no material transfers between the fair value hierarchy levels during 2019 or 2018.

f. Statutory Deposits: Investments, generally certificates of deposit, were on deposit at December 31, 2019 and 2018 to satisfy requirements of regulatory agencies. These assets are included in bonds and cash and cash equivalents in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

g. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other (expense) income in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from three to ten years. Depreciation expense, including that related to the nonadmitted portion, was $194,774 and $195,881 for the years ended December 31, 2019 and 2018, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements was $221,052 and $221,052 for the years ended December 31, 2019 and 2018, respectively.

h. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2019 and 2018 DTAs of $140,442 and $79,830, respectively, were nonadmitted.

i. Earned Premiums: Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet

processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally, pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score was calculated from claims data submitted through EDS. CMS will increase that percentage to 50% in 2020 and has proposed to increase that percentage to 75% in 2021.

The amount of net premiums written by the Company in 2019 and 2018 that were subject to retrospective rating features were $2,196,056,462 and $1,966,532,607, respectively, or 97.57% and 98.33%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $30,255,445 and $19,260,692 as of December 31, 2019 and 2018, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company did not have any rebates incurred, paid or unpaid as of December 31, 2019 and 2018.

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

The risk corridor provisions compare costs targeted in the Company's 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 the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately nine months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation

made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2019 and 2018:

	2019		2018	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 499,862	$ -	$ 1,114,685	$ -
Amounts receivable relating to uninsured plans	-	8,444,091	-	2,117,881
Aggregate health policy reserves	(1,892,346)	-	(2,061,009)	-
Accounts payable and accrued expenses	-	(5,013,876)	-	(4,763,516)
Net (liability) asset	$ (1,392,484)	$ 3,430,215	$ (946,324)	$ (2,645,635)

k. Accounting for the Risk-Sharing Provisions of the Health Care Reform Law: Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party

studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company's risk adjustment data for 2018 was selected for audit by HHS.

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

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2019 and 2018:

HCRL Risk Adjustment		
Assets	**2019**	**2018**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 310,364	$ -
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	24,225	30,968
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	154,529	1,340,537
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	(800,019)	(4,304,043)
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	22,532	29,731

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

HCRL Risk Corridor	2019	2018
Assets		
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	-	3,625
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 414,667	$ 345,229	$ 69,438	$ -	$ -	$ -
2015	3,073,969	3,073,969	-	-	-	-
2016	-	-	-	-	-	-
Total	$ 3,488,636	$ 3,419,198	$ 69,438	$ -	$ -	$ -

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

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the transitional HCRL reinsurance program as of December 31, 2019 and 2018:

	2019	2018
Assets		
Amounts recoverable for claims paid due to HCRL Reinsurance	$ -	$ -
Amounts recoverable for claims unpaid due to HCRL Reinsurance (Contra Liability)	-	-
Amounts receivable relating to uninsured plans for contributions for HCRL Reinsurance	-	-
Liabilities		
Liabilities for contributions payable due to HCRL Reinsurance – not reported as ceded premium	-	-
Ceded reinsurance premiums payable due to HCRL Reinsurance	-	-
Liabilities for amounts held under uninsured plans contributions for HCRL Reinsurance	-	-
Operations (Revenues & Expenses)		
Ceded reinsurance premiums due to HCRL Reinsurance	-	-
Reinsurance recoveries (income statement) due to HCRL Reinsurance payments or expected payments	38,958	966
HCRL Reinsurance contributions – not reported as ceded premiums	-	-

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal government of $3,419,198 in payments for the Company under the risk corridor premium stabilization program established under the HCRL, for the years 2014, 2015 and 2016. Humana's case has been stayed by the Court, pending resolution of similar cases filed by other insurers. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. As such, Humana will continue to seek payments owed to it. The Company has not recognized premiums, nor has it recorded a receivable for any amount due from the federal government for unpaid risk corridor payments as of December 31, 2019. The Company has fully recognized all liabilities due to the federal government that it has incurred under the risk corridor program, and has paid all amounts due to the federal government as required.

In addition to the provisions discussed above, beginning in 2014, HHS paid the Company a portion of the health care costs for low-income individual members for which the Company assumes no risk in accordance with the HCRL. These cost subsidy payments ceased effective October 2017. The Company accounted for these subsidies as a deposit in its statutory statements of admitted assets, liabilities and surplus and as an operating activity in its statements of cash flows. The Company did not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies. Receipt and payment activity was accumulated at the state level and recorded in its statutory statements of admitted assets, liabilities and surplus in health care and other receivables or accounts payable and accrued expenses depending on the state balance at the end of the reporting period.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	-		-		-		310,364		A.	310,364	
2. Premium adjustments (payables) (including high risk pool payments)		(1,340,537)		(2,296,391)		955,854		(955,854)	B.		-
3. Subtotal ACA Permanent Risk Adjustment Program	-	(1,340,537)	-	(2,296,391)	-	955,854	310,364	(955,854)		310,364	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-		38,958		(38,958)		38,958		C.	-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance- not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	-	-	38,958	-	(38,958)	-	38,958	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		-		-		-			-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk Sharing Provisions	-	(1,340,537)	38,958	(2,296,391)	(38,958)	955,854	349,322	(955,854)		310,364	-

Explanation for adjustments

A. Adjustments related to updates received from CMS associated with 2018 benefit year and the latest data from Wakely Consulting.

B. The Small Group Commercial estimate was changed for unfinalized years based on the latest data from Wakely Consulting.

C. Adjustments related to payments received from CMS associated with 2016 benefit year.

Net payments under the 3Rs associated with prior coverage years were $(2,257,433) and $(38,216,126) in 2019 and 2018, respectively.

l. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 8. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2019, 2018, and 2017:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days After Billing
12/31/2019	$ 32,409,099	$ 32,409,099	$ -	$ -	$ -
9/30/2019	37,222,346	37,222,346	36,963,112	-	-
6/30/2019	56,554,808	56,554,808	55,832,379	219,447	-
3/31/2019	39,411,645	39,411,645	39,018,971	-	161,474
12/31/2018	29,286,451	29,286,451	28,890,678	205,376	79,375
9/30/2018	35,112,475	35,112,475	34,969,900	142,575	-
6/30/2018	46,560,483	46,560,483	46,344,117	216,366	-
3/31/2018	32,699,931	32,699,931	32,699,931	-	-
12/31/2017	25,799,613	25,799,613	24,333,998	1,404,638	60,977
9/30/2017	28,052,853	28,052,853	28,042,862	-	9,991
6/30/2017	27,246,040	27,246,040	27,209,756	11,737	24,547
3/31/2017	28,113,407	28,113,407	28,111,744	-	1,663

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $1,104,438 and $142,575 were nonadmitted at December 31, 2019 and 2018, respectively.

m. Benefits Incurred and Loss Adjustment Expenses: Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the

nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $2,021,000 at December 31, 2019 but determined that no premium deficiency liability should be recorded at December 31, 2018. The liability at December 31, 2019 is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

n. Nonadmitted Assets: Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

o. Going Concern Considerations: Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks &*

Uncertainties, and Other Disclosures (SSAP No. 1). Based on this evaluation, Management has determined that there is no substantial doubt about the Company's ability to continue as a going concern.

p. Subsequent Events: The Company evaluated subsequent events through April 30, 2020, the date these financial statements were issued or available to be issued.

On January 1, 2020, the Company will be subject to the annual fee under Section 9010 of the HCRL as described in Note 2(b). The Consolidated Appropriations Act enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurance industry fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurance industry fee, but the fee has resumed for calendar year 2020. No segregation was recorded within special surplus for the annual health insurance industry fee related to the 2018 data year due to the moratorium. The further consolidated Appropriations Act 2020, enacted on December 20, 2019, permanently repealed the health insurance industry fee for calendar years 2021 and thereafter. In 2018, the Company was subject to an annual fee under section 9010 of the HCRL. This annual health insurance industry fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. The 2018 health insurance industry fee was paid September 30, 2018. The impact of the annual health insurance industry fee on the Company's operations as of December 31, 2019 and 2018 were as follows:

	2019	2018
HCRL fee assessment payable	$ 44,204,567	$ -
HCRL fee assessment paid	-	38,168,921
Premium written subject to HCRL 9010 assessment	2,223,799,173	-
Total Adjusted Capital Level before surplus adjustment	279,634,856	252,866,515
Total Adjusted Capital Level after surplus adjustment	235,430,289	252,866,515
Authorized Control Level after surplus adjustment	65,262,954	57,986,150

The Company is not aware of any events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements which may have a material effect on its financial condition.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2019 and 2018 were as follows:

	2019			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 5,917,815	$ 114,078	$ (27,067)	$ 6,004,826
States, territories and possessions	73,422,668	2,447,292	(810)	75,869,150
Political subdivisions of states, territories and possessions	56,152,055	1,221,393	(58,447)	57,315,001
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	130,494,906	2,777,785	(192,874)	133,079,817
Industrial and miscellaneous	138,736,326	2,997,160	(113,937)	141,619,549
Total bonds	$ 404,723,770	$ 9,557,708	$ (393,135)	$ 413,888,343

	2018			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 43,533,781	$ 83,757	$ (1,728,206)	$ 41,889,332
States, territories and possessions	119,014,807	1,840,546	(213,049)	120,642,304
Political subdivisions of states, territories and possessions	48,454,630	550,705	(295,501)	48,709,834
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	73,774,615	553,576	(654,852)	73,673,339
Industrial and miscellaneous	156,741,454	561,760	(2,886,944)	154,416,270
Total bonds	$ 441,519,287	$ 3,590,344	$ (5,778,552)	$ 439,331,079

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The book/adjusted carrying value and estimated fair value of bonds and short-term investments at December 31, 2019, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 68,786,791	$ 69,138,977
Due after one year through five years	204,891,346	209,565,552
Due after five years through ten years	73,258,460	75,283,856
Due after ten years	28,222,225	29,124,296
Mortgage and asset-backed securities	31,065,253	32,275,967
	$ 406,224,075	$ 415,388,648

The detail of realized gains (losses) of bonds for the years ended December 31, 2019 and 2018 were as follows:

	2019	2018
Gross realized gains	$ 260,773	$ 64,943
Gross realized losses	(83,852)	(24,551)
Net realized gains	$ 176,921	$ 40,392

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2019 and 2018 were as follows:

	2019					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ 2,091,701	$ (27,067)	$ 2,091,701	$ (27,067)
States, territories and possessions	-	-	487,227	(810)	487,227	(810)
Political subdivisions of states, territories and possessions	2,889,067	(56,292)	2,377,163	(2,155)	5,266,230	(58,447)
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	9,828,982	(81,419)	19,627,549	(111,455)	29,456,531	(192,874)
Industrial and misc.	-	-	20,896,697	(113,937)	20,896,697	(113,937)
Total invested assets	$ 12,718,049	$ (137,711)	$ 45,480,337	$ (255,424)	$ 58,198,386	$ (393,135)

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

	2018					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 10,697,561	$ (242,275)	$ 29,803,778	$ (1,485,930)	$ 40,501,339	$ (1,728,205)
States, territories and possessions	14,056,982	(62,726)	15,005,393	(150,323)	29,062,375	(213,049)
Political subdivisions of states, territories and possessions	7,330,172	(24,510)	12,124,742	(270,991)	19,454,914	(295,501)
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	12,290,258	(35,142)	31,343,779	(619,710)	43,634,037	(654,852)
Industrial and misc.	38,975,900	(606,955)	80,845,382	(2,279,990)	119,821,282	(2,886,945)
Total invested assets	$ 83,350,873	$ (971,608)	$ 169,123,074	$ (4,806,944)	$ 252,473,947	$ (5,778,552)

The unrealized loss from all securities was generated from 28 investment positions at December 31, 2019. All issuers of securities the Company owns that were trading at an unrealized loss at December 31, 2019 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2019, the Company did not intend to sell the securities with an unrealized loss position, and it is not likely that the Company will be required to sell these securities before recovery of their amortized cost basis. As a result, the Company believes that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2019.

Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2019 and 2018 were as follows:

	2019		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 4,595,881	$ -	$ 4,595,881
Statutory valuation allowance adjustment	-	-	-
Adjusted gross deferred tax assets	4,595,881	-	4,595,881
Deferred tax assets nonadmitted	(140,442)	-	(140,442)
Subtotal net admitted deferred tax assets	4,455,439	-	4,455,439
Gross deferred tax liabilities	(209,744)	-	(209,744)
Net admitted deferred tax asset/(liability)	$ 4,245,695	$ -	$ 4,245,695

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

	2018		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 3,463,924	$ 31,146	$ 3,495,070
Statutory valuation allowance adjustment	-	(31,146)	(31,146)
Adjusted gross deferred tax assets	3,463,924	-	3,463,924
Deferred tax assets nonadmitted	(79,830)	-	(79,830)
Subtotal net admitted deferred tax assets	3,384,094	-	3,384,094
Gross deferred tax liabilities	(279,921)	-	(279,921)
Net admitted deferred tax asset/(liability)	$ 3,104,173	$ -	$ 3,104,173

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2019 and 2018 were as follows:

	December 31, 2019		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 4,186,108	$ -	$ 4,186,108
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	59,587	-	59,587
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	59,587
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	41,308,374
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	209,744	-	209,744
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 4,455,439	$ -	$ 4,455,439

	December 31, 2018		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 3,042,962	$ -	$ 3,042,962
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	61,211	-	61,211
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	61,211
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	37,464,351
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	279,921	-	279,921
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 3,384,094	$ -	$ 3,384,094

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2019	2018
Ratio percentage used to determine recovery period and threshold limitation amount	422%	431%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 275,389,161	$ 249,762,339

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2019 and 2018 consisted of the following:

	2019	2018
Current year income tax provision	$ 20,634,286	$ 16,036,199
Revisions in prior years' estimated taxes	(31,003)	(2,500,849)
Federal income tax expense excluding the tax on realized capital gains (losses) and before change in net deferred income taxes	20,603,283	13,535,350
Tax on realized capital gains (losses)	37,154	(7,157)
Change in net deferred income taxes	(1,202,134)	4,740,495
Total statutory income taxes	$ 19,438,303	$ 18,268,688

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2019 and 2018 were as follows:

	2019	2018	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 3,188,518	$ 2,099,628	$ 1,088,890
Advance premiums	212,465	270,553	(58,088)
Policyholder reserves	-	-	-
Investments	-	-	-
Deferred acquisition costs	251,320	190,472	60,848
Policyholder dividends accrual	-	-	-
Fixed assets	243,601	303,310	(59,709)
Compensation and benefit accruals	-	-	-
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	-	-	-
Bad debts	63,723	279,493	(215,770)
Accrued litigation	-	-	-
CMS Rx reserves	306,097	113,230	192,867
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	296,132	157,635	138,497
Accrued lease	4,696	10,498	(5,802)
Section 197 intangibles	29,329	39,105	(9,776)
Reinsurance fee	-	-	-
Provider contracts	-	-	-
Gross ordinary DTAs	4,595,881	3,463,924	1,131,957
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(140,442)	(79,830)	(60,612)
Admitted ordinary DTAs	4,455,439	3,384,094	1,071,345
Capital			
Investments	-	31,146	(31,146)
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	-	31,146	(31,146)
Statutory valuation allowance adjustment	-	(31,146)	31,146
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 4,455,439	$ 3,384,094	$ 1,071,345

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

	2019	2018	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	-	-	-
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(5,777)	(8,714)	2,937
CMS Rx reserve	-	-	-
Reserve transition adjustment	(203,967)	(271,207)	67,240
Ordinary DTLs	(209,744)	(279,921)	70,177
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(209,744)	(279,921)	70,177
Net deferred tax assets/(liabilities)	$ 4,245,695	$ 3,104,173	$ 1,141,522

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from.

The change in nonadmitted deferred tax assets from December 31, 2018 to 2019 was an increase of $60,612. The change in nonadmitted deferred tax assets from December 31, 2017 to 2018 was a decrease of $1,240,511.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the tax-exempt interest, proration and other, including prior year true-up in 2019.

The Company had no net operating loss carryforwards at December 31, 2019 or 2018.

The following table demonstrates the income tax expense for 2018 and 2019 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2018	$ 15,535,063	$ (7,157)	$ 15,527,906
2019	20,634,286	37,154	20,671,440
	$ 36,169,349	$ 29,997	$ 36,199,346

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return

liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2019 or 2018.

As of December 31, 2019, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana's consolidated income tax returns for 2017 and prior years. Humana's 2018 tax return is in the post-filing review period under the Compliance Assurance Process (CAP). Humana's 2019 tax return is under advance review by the IRS under CAP. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2019 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2019
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	AMERICAN ELDERCARE, INC.	65-0380198
6	ARCADIAN HEALTH PLAN, INC.	20-1001348
7	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
8	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
9	CARENETWORK, INC.	39-1514846
10	CAREPLUS HEALTH PLANS, INC.	59-2598550
11	CARITEN HEALTH PLAN INC.	62-1579044
12	CHA HMO, INC.	61-1279717
13	CHA SERVICE COMPANY, INC.	61-1279716
14	COMPBENEFITS COMPANY	59-2531815
15	COMPBENEFITS CORPORATION	04-3185995
16	COMPBENEFITS DENTAL, INC.	36-3686002
17	COMPBENEFITS DIRECT, INC.	58-2228851
18	COMPBENEFITS INSURANCE COMPANY	74-2552026
19	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

20	CONTINUCARE CORPORATION	59-2716023
21	CONTINUCARE MEDICAL MANAGEMENT, INC.	65-0791417
22	CONTINUCARE MSO, INC.	65-0780986
23	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
24	DENTICARE, INC.	76-0039628
25	EDGE HEALTH MSO, INC.	84-2214810
26	EDGE HEALTH, P.C.	84-2752906
27	EMPHESYS INSURANCE COMPANY	31-0935772
28	EMPHESYS, INC.	61-1237697
29	FAMILY PHYSICIANS OF WINTER PARK, INC.	59-3164234
30	FPG ACQUISITION CORP.	81-3802918
31	FPG ACQUISITION HOLDINGS CORP.	81-3819187
32	FPG HOLDING COMPANY, LLC	32-0505460
33	HARRIS, ROTHENBERG INTERNATIONAL, INC.	27-1649291
34	HEALTH VALUE MANAGEMENT, INC.	61-1223418
35	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
36	HUMANA AT HOME (DALLAS), INC.	75-2739333
37	HUMANA AT HOME (HOUSTON), INC.	76-0537878
38	HUMANA AT HOME (SAN ANTONIO), INC.	01-0766084
39	HUMANA AT HOME (TLC), INC.	75-2600512
40	HUMANA AT HOME 1, INC.	65-0274594
41	HUMANA AT HOME, INC.	13-4036798
42	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
43	HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.	84-3226630
44	HUMANA BENEFIT PLAN OF TEXAS, INC. (f/k/a HUMANA BEHAVIORAL HEALTH, INC.)	75-2043865
45	HUMANA DENTAL COMPANY	59-1843760
46	HUMANA DIGITAL HEALTH AND ANALYTICS PLATFORM SERVICES, INC. (f/k/a TRANSCEND INSIGHTS, INC.)	80-0072760
47	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
48	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
49	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
50	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
51	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
52	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
53	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
54	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
55	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632
56	HUMANA HEALTH PLAN, INC.	61-1013183
57	HUMANA HEALTHCARE RESEARCH, INC.	42-1575099
58	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
59	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
60	HUMANA INSURANCE COMPANY	39-1263473
61	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
62	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
63	HUMANA MARKETPOINT, INC.	61-1343508
64	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
65	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
66	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

67	HUMANA MEDICAL PLAN, INC.	61-1103898
68	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
69	HUMANA PHARMACY, INC.	61-1316926
70	HUMANA REAL ESTATE COMPANY (f/k/a PRESERVATION ON MAIN, INC.)	20-1724127
71	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
72	HUMANA VETERANS HEALTHCARE SERVICES, INC.	20-8418853
73	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
74	HUMANADENTAL INSURANCE COMPANY	39-0714280
75	HUMANADENTAL, INC.	61-1364005
76	HUMCO, INC.	61-1239538
77	HUM-e-FL, INC.	61-1383567
78	MANAGED CARE INDEMNITY, INC.	61-1232669
79	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
80	METCARE OF FLORIDA, INC.	65-0879131
81	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
82	PARTNERS IN INTEGRATED CARE, INC.	47-2905609
83	PARTNERS IN PRIMARY CARE (GA), P.C.	83-2624178
84	PARTNERS IN PRIMARY CARE (KS), P.C.	82-2000699
85	PARTNERS IN PRIMARY CARE (NC), P.C.	82-1926920
86	PARTNERS IN PRIMARY CARE, P.A.	47-1161014
87	PHP COMPANIES, INC.	62-1552091
88	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
89	PRIMARY CARE HOLDINGS, INC.	46-1225873
90	ROHC, LLC	75-2844854
91	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
92	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
93	TEXAS DENTAL PLANS, INC.	74-2352809
94	THE DENTAL CONCERN, INC.	52-1157181
95	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
96	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
97	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105
98	TRANSCEND POPULATION HEALTH MANAGEMENT, LLC	46-5329373

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

5. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2019 and 2018 are summarized as follows:

	2019	2018
Balance at January 1,	$ 171,420,855	$ 189,459,246
Benefits incurred and loss adjustment expenses related to		
Current year	1,975,163,533	1,755,624,658
Prior year	(7,829,493)	(17,862,658)
	1,967,334,040	1,737,762,000
Benefits and loss adjustment expenses paid related to		
Current year	1,770,247,244	1,598,384,131
Prior year	158,356,424	157,416,260
	1,928,603,668	1,755,800,391
Balance at December 31,	$ 210,151,227	$ 171,420,855

Benefits and loss adjustment expenses payable at December 31, 2018 and 2017 ultimately settled during 2019 and 2018 for $7,829,493 and $17,862,658 less, respectively, than the amounts originally estimated as a result of favorable developments of unpaid claims and claim adjustment expenses principally on Medicare operations. These favorable developments were generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. The Company did not record any adjustments to premiums related to prior period claims development.

6. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the Department statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the Department is the lesser of 10% of total surplus, or the greater of net operating gain for the calendar year preceding the dividend or for the 3 calendar years preceding the dividend less dividends paid for the most recent 2 of those calendar years. Based on these restrictions, the Company could have paid a maximum dividend or return of capital to shareholders of approximately $25,280,000 in 2019 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. Extraordinary amounts have been approved by the Department.

		Dividend or Return of Capital Amount		
		Ordinary	Extraordinary	Date Paid
Dividend		$ 25,280,000	$ 24,720,000	April 30, 2019
	Total paid in 2019	$ 25,280,000	$ 24,720,000	
Dividend		$ 4,420,000	$ 77,580,000	April 20, 2018
	Total paid in 2018	$ 4,420,000	$ 77,580,000	

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

7. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Louisiana has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $65,262,954 or the Company, under the discretion of the Commissioner of the Department, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Louisiana which require a minimum capital and surplus level of $130,525,908 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $279,634,856 and $252,866,515 as of December 31, 2019 and 2018, respectively.

8. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $264,508 and $390,802 for the years ended December 31, 2019 and 2018, respectively.

Employees supporting the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2019 and 2018 total allocated expenses associated with these plans were $2,379,744 and $1,800,792, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2019 and 2018 were $222,278,616 and $192,099,708, respectively which are recorded as a charge to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 4, which were $23,875,644 and $18,093,249 for the years ended December 31, 2019 and 2018, respectively. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $16,197,204 and $43,398,493 due from and to Humana at December 31, 2019 and 2018, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

In the ordinary course of business, the Company also directly contracts with related parties to provide services that are routine in nature to its members. The administrative services, access fees, and cost of care services provided are determined within each individual agreement. These amounts are

included in benefits incurred and loss adjustment expenses as well as selling, general and administrative expenses in the statutory statements of revenue and expenses.

The following table identifies the amount for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2019 and 2018, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliate and Other Related Parties* (SSAP No. 25):

	2019	2018
SeniorBridge and Humana At Home, Inc.	$ 18,409,488	$ 20,492,365

SeniorBridge and Humana at Home, Inc. provide in-home care as well as telephonic care management to eligible Humana members.

In addition to the related parties above, the Company also has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(l) for further consideration of related pharmacy rebates. The Company had $588,521,643 and $504,944,099 of administrative service and prescription costs in 2019 and 2018, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives, and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(j).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $180,810,672 and $158,924,835 of prescription costs in 2019 and 2018, respectively, with Humana Pharmacy, Inc.

The Company received no capital contributions in the years ended December 31, 2019 or 2018.

Humana forgave $640,194 of the Company's tax liability due to Humana as part of the Company's tax sharing agreement during 2019. The portion of the tax balance being forgiven is associated with an issue that is currently subject to IRS Appeals. The forgiveness was accounted for as contributed surplus per SSAP No. 72 *Surplus and Quasi-Reorganizations* (SSAP No. 72).

9. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms of one year. Operating lease rental payments charged to expenses for the years ended December 31, 2019 and 2018 was $1,437,327 and $1,495,380, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

Future minimum rental payments required under operating leases as of December 31, 2019, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2020	$	86,118
2021		-
2022		-
2023		-
2024		-
Thereafter		-
Total minimum lease payments	$	86,118

10. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $1,891,053,121 and $1,637,387,185 for the years ended December 31, 2019 and 2018, respectively. The loss of the Contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2020, and all product offerings filed with CMS for 2020 have been approved.

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

CMS is phasing-in the process of calculating risk scores using diagnoses data from the RAPS to diagnoses data from the EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score was calculated from claims data submitted through EDS. CMS will increase that percentage to 50% in 2020 and has proposed to increase that percentage to 75% in 2021. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on the Company's results of statutory statements of revenue and expenses, changes in surplus, or cash flows.

CMS and the Office of the Inspector General of Health and Human Services (HHS-OIG) are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation (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 RADV Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of the government's traditional fee-for-service Medicare program, or Medicare FFS. The Company refers to the process of accounting for errors in FFS claims as the FFS Adjuster. This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for the payment years 2015, 2014 and 2012.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2014. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue

and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana believes that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and has provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus, or cash flows.

Humana believes that, CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS' final rule release regarding MA and Part D prescription drug benefit program regulations for Contract Year 2015 (referred to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each MA risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

The Company 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 the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

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

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

b. COVID-19: The spread of the novel coronavirus, or COVID-19, and the emergence of stay-at-home and physical distancing orders and other restrictions on movement and economic activity intended to reduce the spread of COVID-19 in the second half of March 2020 in the United States of America, has impacted the Company's business. A number of significant variables and uncertainties precludes any estimation as to the ultimate impact from COVID-19 including, among others, the severity and duration of the pandemic, continued actions taken to mitigate the spread of COVID-19 and in turn, relax those restrictions, the timing and degree in resumption of demand for deferred health care services, the ability of our commercial members to pay their premium, the nature and level of diagnostic testing, the cost and timing of new therapeutic treatments and vaccines.

c. Legal Proceedings: During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus, and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus, and cash flows, and may also affect the Company's reputation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided Humana's legal counsel with an information request concerning Humana's Medicare Part C risk adjustment practices. The request relates to Humana's oversight and submission of risk adjustment data generated by providers in its MA network, as well as to its business and compliance practices related to risk adjustment data generated by its providers and by Humana, including medical record reviews conducted as part of its data and payment accuracy compliance efforts, the use of health and well-being assessments, and fraud detection efforts. Humana believes that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of MA plans, providers and vendors. Humana continues to cooperate with and voluntarily respond to the information requests from the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned United States of America ex rel. Steven Scott v. Humana, Inc., in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by Humana in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by it under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. Humana takes seriously its obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations since the transfer to the Western District of Kentucky. Humana has engaged in active discovery with the relator who has pursued the matter on behalf of the United States following its unsealing, and expect that discovery process to conclude in the near future and for the Court to consider its motion for summary judgment.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

d. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

e. Securities & Credit Markets Risks: Volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Supplemental Investment Information

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

Of the **Humana Health Benefit Plan of Louisiana, Inc.**
Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436
NAIC Group Code 0119 NAIC Company Code 95642 Employer's ID Number 72-1279235

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 3 of the statement of admitted assets, liabilities and surplus. $531,017,423.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	State Of Louisiana	BONDS	$ 87,660,611	16.51%
2.02	City of New Orleans	BONDS	12,193,367	2.30%
2.03	Bossier Parish Schools	BONDS	11,499,256	2.17%
2.04	Shreveport Louisiana	BONDS	10,108,117	1.90%
2.05	Louisiana Local Government Environmental Facilities Community Development Authority	BONDS	9,779,323	1.84%
2.06	St. Tammany Parish Wide School District No 12 Louisiana	BONDS	7,383,819	1.39%
2.07	Louisiana Public Facilities Authority	BONDS	5,934,145	1.12%
2.08	3M Company	BONDS	4,999,067	0.94%
2.09	The Procter & Gamble Company	BONDS	4,987,101	0.94%
2.10	United Parcel Service, Inc.	BONDS	4,412,145	0.83%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 383,200,390	72.16%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	19,512,229	3.67%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	1,511,754	0.28%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	1,999,702	0.38%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	-	0.00%	3.12	P/RP-6	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
4.02	Total admitted assets held in foreign investments.	$	2,999,138	0.56%
4.03	Foreign-currency-denominated investments.		-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency		-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	-	0.00%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
6.01	Country:	$	-	0.00%
6.02	Country:		-	0.00%
	Countries rated NAIC - 2			
6.03	Country:	$	-	0.00%
6.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
6.05	Country:	$	-	0.00%
6.06	Country:		-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1 Issuer	2 NAIC Rating	3	4
10.01	-	-	$ -	0.00%
10.02	-	-	-	0.00%
10.03	-	-	-	0.00%
10.04	-	-	-	0.00%
10.05	-	-	-	0.00%
10.06	-	-	-	0.00%
10.07	-	-	-	0.00%
10.08	-	-	-	0.00%
10.09	-	-	-	0.00%
10.10	-	-	-	0.00%

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.			
11.02	Total admitted assets held in Canadian Investments	$	-	0.00%
11.03	Canadian-currency-denominated investments		-	0.00%
11.04	Canadian-denominated insurance liabilities		-	0.00%
11.05	Unhedged Canadian currency exposure		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ -	0.00%
	Largest 3 investments with contractual sales restrictions		
12.03		-	0.00%
12.04		-	0.00%
12.05		-	0.00%

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

	1	2	3
	Name of Issuer		
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02	-	$ -	0.00%
16.03	-	-	0.00%
16.04	-	-	0.00%
16.05	-	-	0.00%
16.06	-	-	0.00%
16.07	-	-	0.00%
16.08	-	-	0.00%
16.09	-	-	0.00%
16.10	-	-	0.00%
16.11	-	-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02	-	$ -	0.00%
18.03	-	-	0.00%
18.04	-	-	0.00%
18.05	-	-	0.00%
18.06	-	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:	**2**	**3**
		$ -	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description **1**	**2**	**3**
19.03	-	$ -	0.00%
19.04	-	-	0.00%
19.05	-	-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2019

		Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
		1 Amount	2 Percentage	1 Amount	2 Percentage
1. Long-Term Bonds					
1.01	U.S. governments	$ 5,917,815	1.38%	$ 5,917,815	1.38%
1.02	All other governments	-	0.00%	-	0.00%
1.03	U.S. states, territories and possessions, etc. guaranteed	73,422,668	17.09%	73,422,668	17.09%
1.04	U.S. political subdivisions of states, territories, and possessions, guaranteed	56,152,055	13.07%	56,152,055	13.07%
1.05	U.S. special revenue and special assessment obligations, etc. non-guaranteed	130,494,906	30.38%	130,494,906	30.38%
1.06	Industrial and miscellaneous	138,736,326	32.30%	138,736,326	32.30%
1.07	Hybrid securities	-	0.00%	-	0.00%
1.08	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
1.09	SVO identified funds	-	0.00%	-	0.00%
1.10	Unaffiliated Bank loans	-	0.00%	-	0.00%
1.11	Total long-term bonds	404,723,770	94.22%	404,723,770	94.22%
2. Preferred stocks					
2.01	Industrial and miscellaneous (Unaffiliated)	-	0.00%	-	0.00%
2.02	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
2.03	Total preferred stocks	-	0.00%	-	0.00%
3. Common stocks					
3.01	Industrial and miscellaneous Publicly traded (Unaffiliated)	-	0.00%	-	0.00%
3.02	Industrial and miscellaneous Other (Unaffiliated)	-	0.00%	-	0.00%
3.03	Parent, subsidiaries and affiliates Publicly traded	-	0.00%	-	0.00%
3.04	Parent, subsidiaries and affiliates Other	-	0.00%	-	0.00%
3.05	Mutual funds	-	0.00%	-	0.00%
3.06	Unit investment trusts	-	0.00%	-	0.00%
3.07	Closed-end funds	-	0.00%	-	0.00%
3.08	Total common stocks	-	0.00%	-	0.00%
4. Mortgage loans					
4.01	Farm mortgages	-	0.00%	-	0.00%
4.02	Residential mortgages	-	0.00%	-	0.00%
4.03	Commercial mortgages	-	0.00%	-	0.00%
4.04	Mezzanine real estate loans	-	0.00%	-	0.00%
4.05	Total mortgage loans	-	0.00%	-	0.00%
5. Real estate					
5.01	Properties occupied by company	-	0.00%	-	0.00%
5.02	Properties held for production of income	-	0.00%	-	0.00%
5.03	Properties held for sale	-	0.00%	-	0.00%
5.04	Total real estate	-	0.00%	-	0.00%
6. Cash, cash equivalents and short-term investments					
6.01	Cash	(3,000,915)	(0.70)%	(3,000,915)	(0.70)%
6.02	Cash equivalents	26,303,500	6.12%	26,303,500	6.12%
6.03	Short-term investments	1,500,305	0.35%	1,500,305	0.35%
6.04	Total cash, cash equivalents and short-term investments	24,802,890	5.78%	24,802,890	5.78%
7. Contract loans		-	0.00%	-	0.00%
8. Derivatives		-	0.00%	-	0.00%
9. Other invested assets		-	0.00%	-	0.00%
10. Receivables for securities		5,431	0.00%	5,431	0.00%
11. Securities Lending		-	0.00%	-	0.00%
12. Other invested assets		-	0.00%	-	0.00%
13.	Total invested assets	$ 429,532,091	100.00%	$ 429,532,091	100.00%

Humana Health Benefit Plan of Louisiana, Inc.

(a wholly owned subsidiary of Humana Insurance Company, a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2018 and 2017

Humana Health Benefit Plan of Louisiana, Inc.
Index
Statutory Basis of Accounting
December 31, 2018 and 2017

Page

Report of Independent Auditors 1

Financial Statements

Statements of Admitted Assets, Liabilities and Surplus 3

Statements of Revenue and Expenses 4

Statements of Changes in Surplus 5

Statements of Cash Flows 6

Notes to Financial Statements 7

Supplemental Investment Information

Investment Risk Interrogatories 42

Summary Investment Schedule 51

Report of Independent Auditors

To the Board of Directors of Humana Health Benefit Plan of Louisiana, Inc.

We have audited the accompanying statutory financial statements of Humana Health Benefit Plan of Louisiana, Inc., which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2018 and 2017, and the related statutory statements of revenue and expenses and changes in surplus, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

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Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2018 and 2017, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana described in Note 2.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements taken as a whole. The supplemental investment risk interrogatories and summary investment schedule (collectively, the "supplemental schedules") of the Company, as of December 31, 2018 and for the year then ended, are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the statutory-basis financial statements. The supplemental schedules are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The supplemental schedules have been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental schedules are fairly stated, in all material respects, in relation to the statutory-basis financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 29, 2019

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2018 and 2017

	2018	2017
Admitted Assets		
Cash and invested assets		
Bonds	$ 441,519,287	$ 425,788,621
Short-term investments	2,116,963	-
Total invested assets	443,636,250	425,788,621
Cash and cash equivalents	(4,639,916)	99,480,551
Total cash and invested assets	438,996,334	525,269,172
Premiums receivable	22,811,704	21,389,084
Investment income due and accrued	4,563,864	4,206,990
Amounts receivable relating to uninsured plans	2,117,881	2,082,352
Reinsurance receivable	-	735,327
Health care and other receivables	30,485,392	25,789,768
Current federal income tax recoverable	1,005,665	-
Net deferred tax assets	3,104,173	6,604,157
Furniture and equipment, less accumulated depreciation of $1,050,006 and $854,252 in 2018 and 2017, respectively	1,209,176	1,411,589
Receivable from Humana Inc.	-	8,087,234
Total admitted assets	$ 504,294,189	$ 595,575,673
Liabilities		
Benefits and loss adjustment expenses payable	$ 171,420,855	$ 189,459,246
Aggregate health policy reserves	17,668,913	60,812,209
Aggregate health claim reserves	558,000	181,000
Advance premiums	6,481,459	11,432,138
Accounts payable and accrued expenses	11,899,954	34,413,312
Current federal income tax payable	-	4,991,647
Payable to Humana Inc.	43,398,493	-
Total liabilities	251,427,674	301,289,552
Surplus		
Common stock, $0 par value; $1 per share stated value; 1,000 shares authorized; 1,000 shares issued and outstanding	1,000	1,000
Special surplus - projected HCRL fee assessment	-	41,411,031
Paid-in surplus	65,760,152	65,993,254
Unassigned surplus	187,105,363	186,880,836
Total surplus	252,866,515	294,286,121
Total liabilities and surplus	$ 504,294,189	$ 595,575,673

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2018 and 2017

	2018	2017
Earned premiums	$ 2,000,006,063	$ 2,080,330,454
Expenses		
Benefits incurred and loss adjustment expenses	1,737,762,000	1,775,090,662
Selling, general and administrative expenses	221,383,809	197,809,059
Changes in aggregate health policy reserves	(4,377,075)	(2,112,723)
Total expenses	1,954,768,734	1,970,786,998
Net underwriting gain	45,237,329	109,543,456
Net investment income	13,415,748	11,659,815
Net realized capital losses on investments (net of capital gains tax of $(7,157) and $(635), respectively)	(26,924)	(1,179)
Net other income	86,042	13,314
Income before federal income tax expense	58,712,195	121,215,406
Federal income tax expense	13,535,350	39,305,540
Net income	$ 45,176,845	$ 81,909,866

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2018 and 2017

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2017	1,000	$ 1,000	$ -	$ 65,993,254	$ 178,182,446	$ 244,176,700
Net income	-	-	-	-	81,909,866	81,909,866
Projected HCRL fee assessment	-	-	41,411,031	-	(41,411,031)	-
Change in net unrealized capital gain, less capital gains tax of $0	-	-	-	-	84,450	84,450
Change in net deferred income taxes	-	-	-	-	(6,637,820)	(6,637,820)
Change in nonadmitted assets	-	-	-	-	410,067	410,067
Correction of prior period error	-	-	-	-	(657,142)	(657,142)
Dividends or return of capital paid	-	-	-	-	(25,000,000)	(25,000,000)
Balances at December 31, 2017	1,000	1,000	41,411,031	65,993,254	186,880,836	294,286,121
Net income	-	-	-	-	45,176,845	45,176,845
HCRL fee moratorium	-	-	(41,411,031)	-	41,411,031	-
Change in net unrealized capital loss, less capital gains tax of $0	-	-	-	-	(148,313)	(148,313)
Change in net deferred income taxes	-	-	-	-	(4,740,495)	(4,740,495)
Change in nonadmitted assets	-	-	-	-	525,459	525,459
Other	-	-	-	(233,102)	-	(233,102)
Dividends or return of capital paid	-	-	-	-	(82,000,000)	(82,000,000)
Balances at December 31, 2018	1,000	$ 1,000	$ -	$ 65,760,152	$ 187,105,363	$ 252,866,515

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2018 and 2017

	2018	2017
Cash flows from operations		
Premiums collected, net of reinsurance	$ 1,951,079,414	$ 2,097,109,819
Net investment income received	16,818,041	14,501,604
Benefits paid	(1,690,941,575)	(1,675,155,481)
Selling, general and administrative expenses paid	(307,647,364)	(253,673,668)
Federal income taxes paid	(19,525,505)	(42,772,654)
Net cash (used for) from operations	(50,216,989)	140,009,620
Cash flows from investments		
Proceeds from investments sold or matured	54,455,459	21,985,304
Cost of investments acquired	(74,127,686)	(81,183,430)
Net cash used for investments	(19,672,227)	(59,198,126)
Cash flows from financing and miscellaneous sources		
Dividends or return of capital paid	(82,000,000)	(25,000,000)
Other cash provided (applied)	49,885,712	(5,657,697)
Net cash used for financing and miscellaneous sources	(32,114,288)	(30,657,697)
Net change in cash, cash equivalents and short-term investments	(102,003,504)	50,153,797
Cash, cash equivalents and short-term investments		
Beginning of year	99,480,551	49,326,754
End of year	$ (2,522,953)	$ 99,480,551

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

1. Reporting Entity

Humana Health Benefit Plan of Louisiana, Inc. (the Company), a wholly owned subsidiary of Humana Insurance Company (HIC), a wholly owned subsidiary of CareNetwork, Inc. (CNI), a wholly owned subsidiary of Humana, is a health maintenance organization (HMO) domiciled in the state of Louisiana and is authorized to sell health plan products therein. The Company is subject to regulation by the federal government and the Louisiana Department of Insurance (the Department). State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 9, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 8.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 12(a).

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the Department, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(n), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Policy and contract liabilities are reported net of reinsurance ceded amounts and any gains from reinsurance transactions are included as a component of surplus, whereas under GAAP, assets and liabilities related to reinsurance ceded contracts are reported on a gross basis and reinsurance transaction gains are reported as a liability;

viii. Comprehensive income disclosures required by GAAP are omitted; and

ix. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

The Department adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The Department has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. The Commissioner of Insurance of the State of Louisiana allows the Company to admit its furniture and equipment used for Health Maintenance Organization operations, which is not in accordance with NAIC SSAP. The Company's risk-based capital would have not triggered a regulatory event had it not used a prescribed or permitted practice.

The statutory financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department. A reconciliation of the Company's surplus based on practices prescribed by the Department to surplus based on Codification at December 31, 2018 and 2017 is shown below:

	2018	2017
Surplus – State of Louisiana basis	$ 252,866,515	$ 294,286,121
State prescribed practices		
a. Furniture and equipment	(1,209,176)	(1,411,589)
Surplus – Codification	$ 251,657,339	$ 292,874,532

The preparation of the Company's financial statements requires management to make estimates and assumptions that affect (a) the reported amounts of assets and liabilities, (b) disclosure of contingent assets and liabilities at the date of the financial statements, and (c) reported amounts of revenues and expenses during the reporting period. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health

Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL 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 (MA) 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 HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee levied on the insurance industry is $14.3 billion in 2018, and is not deductible for income tax purposes, which significantly increases the Company's effective income tax rate. A one year suspension of the health insurance industry fee, as the Company experienced in 2017 and is experiencing in 2019, significantly impacts the Company's trend in key operating metrics including the Company's operating cost and medical expense ratios, as well as its effective tax rate. The annual health insurance industry fee is scheduled to resume for calendar year 2020 under current law.

As noted above, the HCRL required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Although the Company previously participated in these exchanges by offering on-exchange individual commercial medical plans, effective January 1, 2018, the Company has exited its Individual Commercial medical business.

It is reasonably possible that the HCRL and related regulations, as well as future legislative, judicial or regulatory changes, including restrictions on Humana's ability to manage its provider network or otherwise operate its business, or restrictions on profitability, including reviews by regulatory bodies that may compare its MA profitability to its non-MA business profitability or compare the profitability of various products within its MA business, and require that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on Humana's results of operations, (including restricting premiums, enrollment and premium growth in certain products and market segments, restricting Humana's ability to expand into new markets, increasing its medical and operating costs, further lowering its Medicare payment rates and increasing its expenses associated with the non-deductible health insurance industry fee and other assessments); its financial position; and its cash flows. Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace HCRL or declare all or certain portions of the HCRL unconstitutional, creates uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

c. Cash, Cash Equivalents and Short-Term Investments: Investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. Investments: Bonds, including loan-backed and structured securities, with a NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as (a) the length of time and extent to which the fair value has been less than cost, (b) adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, (c) payment structure of the security, (d) changes in credit rating of the security by the rating agencies, (e) the volatility of the fair value changes, (f) changes in fair value of the security after the balance sheet date, and (g) the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as (a) the length of time and extent to which the fair value has been less than cost, (b) adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, (c) payment structure of the security, (d) changes in credit rating of the security by the rating agencies, (e) the volatility of the fair value changes, (f) changes in fair value of the security after the balance sheet date, and (g) cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2018 or December 31, 2017.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted. No portion of the investment income due and accrued was nonadmitted at December 31, 2018 or 2017.

For other restricted assets reported in aggregate, the pledged amounts with the Department were $1,000,000 and $1,000,000, which is 0.20% and 0.17%, of gross assets and 0.20% and 0.17%, of net admitted assets at December 31, 2018 and 2017, respectively.

e. Fair Value: In accordance with SSAP No. 100, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the

determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2018 or 2017.

There were no financial assets carried at fair value at December 31, 2017. The fair value of financial assets carried at fair value at December 31, 2018 were as follows:

	Fair Value Measurements at December 31, 2018			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Corporate debt securities	-	3,367,500	-	3,367,500
Total invested assets	$ -	$ 3,367,500	$ -	$ 3,367,500

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2018 and 2017 were as follows:

	December 31, 2018					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and short-term investments	$ 441,448,042	$ 443,636,250	$ -	$ 441,448,042	$ -	$ -

	December 31, 2017					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and cash equivalents	$ 450,340,608	$ 445,795,565	$ 20,006,943	$ 430,333,665	$ -	$ -

The Company reports transfers between fair value hierarchy levels at the end of the reporting period. There were no material transfers between the fair value hierarchy levels during 2018 or 2017.

f. Statutory Deposits: Investments, generally certificates of deposit, were on deposit at December 31, 2018 and 2017 to satisfy requirements of regulatory agencies. These assets are included in bonds and cash and cash equivalents in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

g. Equipment: Equipment is recorded at cost less accumulated depreciation. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from three to ten years. Depreciation expense, including that related to the nonadmitted portion, was $195,881 and $203,427 for the years ended December 31, 2018 and 2017, respectively. Gains and losses on sales or disposals of property and equipment are included in net other income in the accompanying statements of revenue and expenses.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements was $221,052 and $218,279 for the years ended December 31, 2018 and 2017, respectively.

h. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates. Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2018 and 2017 DTAs of $79,830 and $1,320,341, respectively, were nonadmitted.

i. Earned Premiums: Premiums are reported as earned in the period in which members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS utilizes a risk adjustment model which apportions premiums paid to MA plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally, pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases payments on a comparison of beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. The Company generally relies on providers, including certain providers in its network who are Humana employees, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for payments received from CMS under the actuarial risk-adjustment model. The Company also relies on providers to appropriately document all medical data, including the diagnosis data submitted with claims. The Company estimates risk-adjustment premiums based on medical diagnoses for its membership. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2017, 25% of the risk score was calculated from claims data submitted through EDS.

The amount of net premiums written by the Company in 2018 and 2017 that were subject to retrospective rating features were $1,966,532,607 and $2,060,232,475, respectively, or 98.33% and 99.03%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $19,260,692 and $16,158,088 as of December 31, 2018 and 2017, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS).

Pursuant to the HCRL, the Company did not have any rebates incurred, paid or unpaid as of December 31, 2018 and 2017.

j. Medicare Part D: The Company covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments received monthly from CMS and members, which are determined from the Company's annual bid, represent amounts for providing prescription drug insurance coverage. The Company recognizes premiums revenue for providing this insurance coverage ratably over the term of its annual contract. The CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain

discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which the Company is not at risk.

The risk corridor provisions compare costs targeted in the Company's 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 the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately nine months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2018 and 2017:

	2018		2017	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 1,114,685	$ -	$ -	$ -
Amounts receivable relating to uninsured plans	-	2,117,881	-	2,082,352
Aggregate health policy reserves	(2,061,009)	-	(8,874,795)	-
Accounts payable and accrued expenses	-	(4,763,516)	-	(22,361,727)
Net liability	$ (946,324)	$ (2,645,635)	$ (8,874,795)	$ (20,279,375)

k. Accounting for the Risk-Sharing Provisions of the Health Care Reform Law: Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member

demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company's risk adjustment data for 2017 was selected for audit by HHS.

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

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2018 and 2017:

HCRL Risk Adjustment		
Assets	**2018**	**2017**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ -	$ -
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	30,968	60,046
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	1,340,537	35,992,537
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	(4,304,043)	(45,597,207)
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	29,731	62,171

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

HCRL Risk Corridor	2018	2017
Assets		
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	3,625	4,119
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 414,667	$ 345,229	$ 69,438	$ -	$ -	$ -
2015	3,073,969	3,073,969	-	-	-	-
2016	-	-	-	-	-	-
Total	$ 3,488,636	$ 3,419,198	$ 69,438	$ -	$ -	$ -

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

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the transitional HCRL reinsurance program as of December 31, 2018 and 2017:

	2018	2017
Assets		
Amounts recoverable for claims paid due to HCRL Reinsurance	$ -	$ 735,327
Amounts recoverable for claims unpaid due to HCRL Reinsurance (Contra Liability)	-	-
Amounts receivable relating to uninsured plans for contributions for HCRL Reinsurance	-	-
Liabilities		
Liabilities for contributions payable due to HCRL Reinsurance – not reported as ceded premium	-	-
Ceded reinsurance premiums payable due to HCRL Reinsurance	-	-
Liabilities for amounts held under uninsured plans contributions for HCRL Reinsurance	-	-
Operations (Revenues & Expenses)		
Ceded reinsurance premiums due to HCRL Reinsurance	-	-
Reinsurance recoveries (income statement) due to HCRL Reinsurance payments or expected payments	966	1,107,754
HCRL Reinsurance contributions – not reported as ceded premiums	-	-

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal government of $3,419,198 in payments for the Company under the risk corridor premium stabilization program established under the HCRL, for the years 2014, 2015 and 2016. Humana's case has been stayed by the Court, pending resolution of similar cases filed by other insurers.

In addition to the provisions discussed above, beginning in 2014, HHS paid the Company a portion of the health care costs for low-income individual members for which the Company assumes no risk in accordance with the HCRL. These cost subsidy payments ceased effective October 2017. The Company accounted for these subsidies as a deposit in its statutory statements of admitted assets, liabilities and surplus and as an operating activity in its statements of cash flows. The Company did not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies. Receipt and payment activity was accumulated at the state level and recorded in its statutory statements of admitted assets, liabilities and surplus in health care and other receivables or accounts payable and accrued expenses depending on the state balance at the end of the reporting period.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)			1,040		(1,040)		1,040		A.	-	
2. Premium adjustments (payables) (including high risk pool payments)		(35,992,537)		(38,957,083)		2,964,546		(2,964,546)	B.		-
3. Subtotal ACA Permanent Risk Adjustment Program		(35,992,537)	1,040	(38,957,083)	(1,040)	2,964,546	1,040	(2,964,546)		-	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	735,327		736,293		(966)		966		C.	-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance- not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	735,327	-	736,293	-	(966)	-	966	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		3,625		(3,625)		3,625		D.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	3,625	-	(3,625)	-	3,625	-		-	-
d. Total for ACA Risk Sharing Provisions	735,327	(35,992,537)	740,958	(38,957,083)	(5,631)	2,964,546	5,631	(2,964,546)		-	-

Explanation for adjustments

A. Adjustments recorded to the 2017 risk adjustment receivable to align with the CMS payment report.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

B. Adjustments recorded to the 2017 risk adjustment payable to align with the CMS payment report.

C. Adjustments recorded to the 2017 reinsurance receivable to align with the CMS payment report.

D. Adjustments recorded for additional risk corridor payments received in 2018 that had been previously written off.

Net payments under the 3Rs associated with prior coverage years were $(38,216,126) and $(37,580,454) in 2018 and 2017, respectively. The Company collected all reinsurance recoverables relating to prior coverage years in 2018.

A roll-forward of risk corridor assets, gross of any nonadmissions and liability balances by program year, along with the reasons for adjustments to prior year balances are presented below.

	Accrued as of December 31 of the Prior Reporting Year		Received or Paid as of the Current Period on Business Written for the Risk Corridors Program Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Accrued Less Payments (Col 1 -3)	Accrued Less Payments (Col 2 -4)	Balances	Balances		Cumulative Balance (Col 1-3+7)	Cumulative Balance (Col 4-4+8)
	1	2	3	4	5	6	7	8		9	10
Risk Corridors Program Year	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
2014 Accrued retrospective premium	-		3,625		(3,625)		3,625		A.	-	
2014 Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
2015 Accrued retrospective premium	-		-		-		-			-	
2015 Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
2016 Accrued retrospective premium	-		-		-		-			-	
2016 Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
Total for Risk Corridors	-	-	3,625	-	(3,625)	-	3,625	-		-	-

Explanation for adjustments

A. Adjustments recorded for additional risk corridor payments received in 2018 that had been previously written off.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

l. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 10. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2018, 2017, and 2016:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days After Billing
12/31/2018	$ 29,286,451	$ 29,286,451	$ -	$ -	$ -
9/30/2018	35,112,475	35,112,475	34,969,900	-	-
6/30/2018	46,560,483	46,560,483	46,344,117	216,366	-
3/31/2018	32,699,931	32,699,931	32,699,931	-	-
12/31/2017	25,799,613	25,799,613	24,333,998	1,404,638	60,977
9/30/2017	28,052,853	28,052,853	28,042,862	-	9,991
6/30/2017	27,246,040	27,246,040	27,209,756	11,737	24,547
3/31/2017	28,113,407	28,113,407	28,111,744	-	1,663
12/31/2016	20,235,789	20,235,789	20,212,624	23,164	-
9/30/2016	21,015,847	21,015,847	21,015,456	-	391
6/30/2016	19,032,237	19,032,237	19,011,108	-	21,129
3/31/2016	17,168,281	17,168,281	17,157,249	-	11,032

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $142,575 and $34,538 were nonadmitted at December 31, 2018 and 2017, respectively.

m. Benefits Incurred and Loss Adjustment Expenses: Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued.

The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company determined that no premium deficiency liability should be recorded at December 31, 2018 and 2017 within aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

n. Nonadmitted Assets: Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, furniture and equipment, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

o. Going Concern Considerations: Effective December 31, 2016, the Company adopted revisions to SSAP No. 1, *Disclosure of Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). The revisions require management of the Company to evaluate whether there is substantial doubt about the Company's ability to continue as a going concern and provide certain disclosures if substantial doubt exists. Management of the Company has completed its evaluation of the Company and determined that there is no substantial doubt about its ability to continue as a going concern.

p. Subsequent Events: The Company evaluated subsequent events through April 29, 2019, the date these financial statements were issued or available to be issued.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

On January 1, 2019, the Company will not be subject to the annual fee under Section 9010 of the Federal HCRL as described in Note 2(b). The Consolidated Appropriations Act enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurer fee, but the fee is scheduled to resume in calendar year 2020. Based on the moratorium no segregation was recorded within special surplus for the annual health insurance industry fee related to the 2018 data year. In 2018, the Company was subject to an annual fee under section 9010 of the Federal HCRL. This annual fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. The 2018 fee was included in 2017 special surplus and paid September 30, 2018. The impact of the annual health insurance industry fee on the Company's operations as of December 31, 2018 and 2017 were as follows:

	2018	2017
HCRL fee assessment payable	$ -	$ 41,411,031
HCRL fee assessment paid	38,168,921	-
Premium written subject to HCRL 9010 assessment	-	2,079,327,783
Total Adjusted Capital Level before surplus adjustment	252,866,515	294,286,121
Total Adjusted Capital Level after surplus adjustment	252,866,515	252,875,090
Authorized Control Level after surplus adjustment	57,986,150	56,483,650

The Company is not aware of any events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements which may have a material effect on its financial condition.

3. Correction of Prior Period Errors

In April of 2017, the Company determined that two ongoing provider disputes related to plan year 2016 would result in additional claims of $981,460. This resulted in the 2016 benefits and loss adjustment expenses payable to be understated by $981,460. The income statement, within benefits incurred and loss adjustment expenses, was also understated by $981,460 and federal and state taxes were overstated by $324,317. Consistent with SSAP No. 3, *Accounting Changes and Corrections of Errors* (SSAP No. 3), the net impact of the claims dispute for 2016 after the tax impact was recorded as an adjustment to unassigned surplus. The full amount of the 2016 disputed claims was settled during the second quarter of 2017.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

4. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2018 and 2017 were as follows:

	2018			
	Book/ Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 43,533,781	$ 83,757	$ (1,728,206)	$ 41,889,332
States, territories and possessions	119,014,807	1,840,546	(213,049)	120,642,304
Political subdivisions of states, territories and possessions	48,454,630	550,705	(295,501)	48,709,834
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	73,774,615	553,576	(654,852)	73,673,339
Industrial and miscellaneous	156,741,454	561,760	(2,886,944)	154,416,270
Total bonds	$ 441,519,287	$ 3,590,344	$ (5,778,552)	$ 439,331,079

	2017			
	Book/ Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 34,282,432	$ 154,090	$ (1,020,254)	$ 33,416,268
States, territories and possessions	110,472,629	2,980,579	(164,110)	113,289,098
Political subdivisions of states, territories and possessions	46,396,584	1,111,884	(266,079)	47,242,389
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	60,330,104	819,332	(483,979)	60,665,457
Industrial and miscellaneous	174,306,872	2,297,585	(884,004)	175,720,453
Total bonds	$ 425,788,621	$ 7,363,470	$ (2,818,426)	$ 430,333,665

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The book/adjusted carrying value and estimated fair value of bonds and short-term investments at December 31, 2018, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 32,888,852	$ 32,672,236
Due after one year through five years	207,613,289	206,263,830
Due after five years through ten years	142,685,450	142,792,931
Due after ten years	49,185,995	48,408,271
Mortgage and asset-backed securities	11,262,664	11,310,774
	$ 443,636,250	$ 441,448,042

The detail of realized gains (losses) of bonds for the years ended December 31, 2018 and 2017 were as follows:

	2018	2017
Gross realized gains	$ 64,943	$ 3,945
Gross realized losses	(24,551)	(5,759)
Net realized gains (losses)	$ 40,392	$ (1,814)

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2018 and 2017 were as follows:

	2018					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 10,697,561	$ (242,275)	$ 29,803,778	$ (1,485,930)	$ 40,501,339	$ (1,728,206)
States, territories and possessions	14,056,982	(62,726)	15,005,393	(150,323)	29,062,375	(213,049)
Political subdivisions of states, territories and possessions	7,330,172	(24,510)	12,124,742	(270,991)	19,454,914	(295,501)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	12,290,258	(35,142)	31,343,779	(619,710)	43,634,037	(654,852)
Industrial and misc.	38,975,900	(606,955)	80,845,382	(2,279,990)	119,821,282	(2,886,944)
Total invested assets	$ 83,350,873	$ (971,608)	$ 169,123,074	$ (4,806,944)	$ 252,473,947	$ (5,778,552)

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

	2017					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 10,376,207	$ (91,514)	$ 20,240,482	$ (928,740)	$ 30,616,689	$ (1,020,254)
States, territories and possessions	10,654,451	(77,820)	8,726,085	(86,290)	19,380,536	(164,110)
Political subdivisions of states, territories and possessions	3,536,792	(34,729)	8,889,810	(231,350)	12,426,602	(266,079)
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	14,391,618	(187,537)	18,011,338	(296,442)	32,402,956	(483,979)
Industrial and misc.	59,439,917	(337,493)	29,504,600	(546,511)	88,944,517	(884,004)
Total invested assets	$ 98,398,985	$ (729,093)	$ 85,372,315	$ (2,089,333)	$ 183,771,300	$ (2,818,426)

The unrealized loss from all securities was generated from 136 investment positions at December 31, 2018. All issuers of securities the Company owns that were trading at an unrealized loss at December 31, 2018 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2018, the Company did not intend to sell the securities with an unrealized loss position, and it is not likely that the Company will be required to sell these securities before recovery of their amortized cost basis. As a result, the Company believes that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2018. Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

5. Reinsurance

The Company reinsures portions of its business through various reinsurance treaties. These treaties protect the Company from sustaining losses above predetermined levels and are included as a reduction of earned premiums in the accompanying statements of revenue and expenses. Although the reinsurer in each case is primarily liable on the insurance ceded, the Company remains liable to the insured whether or not the reinsurer meets its contractual obligations.

The Company has reinsurance contracts with various insurers. For the year ended December 31, 2017 there were $3,014 premiums ceded related to these contracts. No premiums were ceded in 2018.

In 2018 and 2017, the Company did not commute any ceded reinsurance, nor did it enter into or engage in any agreement that reinsures policies or contracts that were in-force or had existing reserves as of the effective date of such agreements. No write-offs of reinsurance balances occurred in 2018 or 2017. The Company remains obligated for amounts ceded in the event that reinsurers do not meet their obligations.

The Company has not entered into any reinsurance agreements in which the reinsurer may unilaterally cancel any reinsurance for reasons other than nonpayment of premiums or other amounts due. The Company does not have any reinsurance agreements in effect in which the amount of losses paid or accrued through December 31, 2018 or 2017 would result in a payment to

the reinsurer of amounts which, in the aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premiums collected under the reinsured policies.

6. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2018 and 2017 were as follows:

	2018		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 3,463,924	$ 31,146	$ 3,495,070
Statutory valuation allowance adjustment	-	(31,146)	(31,146)
Adjusted gross deferred tax assets	3,463,924	-	3,463,924
Deferred tax assets nonadmitted	(79,830)	-	(79,830)
Subtotal net admitted deferred tax assets	3,384,094	-	3,384,094
Gross deferred tax liabilities	(279,921)	-	(279,921)
Net admitted deferred tax asset/(liability)	$ 3,104,173	$ -	$ 3,104,173

	2017		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 7,930,861	$ -	$ 7,930,861
Statutory valuation allowance adjustment	-	-	-
Adjusted gross deferred tax assets	7,930,861	-	7,930,861
Deferred tax assets nonadmitted	(1,320,341)	-	(1,320,341)
Subtotal net admitted deferred tax assets	6,610,520	-	6,610,520
Gross deferred tax liabilities	(6,363)	-	(6,363)
Net admitted deferred tax asset/(liability)	$ 6,604,157	$ -	$ 6,604,157

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2018 and 2017 were as follows:

	December 31, 2018		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 3,042,962	$ -	$ 3,042,962
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	61,211	-	61,211
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	61,211
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	37,464,351
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	279,921	-	279,921
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 3,384,094	$ -	$ 3,384,094

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

	December 31, 2017		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 6,190,238	$ -	$ 6,190,238
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	413,919	-	413,919
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	413,919
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	43,152,295
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	6,363	-	6,363
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 6,610,520	$ -	$ 6,610,520

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2018	2017
Ratio percentage used to determine recovery period and threshold limitation amount	431%	509%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 249,762,339	$ 287,681,964

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2018 and 2017 consisted of the following:

	2018	2017
Current year income tax provision	$ 16,036,199	$ 39,604,558
Revisions in prior years' estimated taxes	(2,500,849)	(299,018)
Federal income tax expense excluding the tax on realized capital losses and before change in net deferred income taxes	13,535,350	39,305,540
Tax on realized capital losses	(7,157)	(635)
Change in net deferred income taxes	4,740,495	6,637,820
Correction of prior period error	-	(297,986)
Total statutory income taxes	$ 18,268,688	$ 45,644,739

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2018 and 2017 were as follows:

	2018	2017	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 2,099,628	$ 3,501,462	$ (1,401,834)
Advance premiums	270,553	477,239	(206,686)
Policyholder reserves	-	788,471	(788,471)
Investments	-	-	-
Deferred acquisition costs	190,472	2,333,335	(2,142,863)
Policyholder dividends accrual	-	-	-
Fixed assets	303,310	306,830	(3,520)
Compensation and benefit accruals	-	-	-
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	-	-	-
Bad debts	279,493	122,278	157,215
Accrued litigation	-	-	-
CMS Rx reserves	113,230	154,860	(41,630)
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	157,635	178,706	(21,071)
Accrued lease	10,498	18,800	(8,302)
Section 197 intangibles	39,105	48,880	(9,775)
Reinsurance fee	-	-	-
Provider contracts	-	-	-
Gross ordinary DTAs	3,463,924	7,930,861	(4,466,937)
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(79,830)	(1,320,341)	1,240,511
Admitted ordinary DTAs	3,384,094	6,610,520	(3,226,426)
Capital			
Investments	31,146	-	31,146
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	31,146	-	31,146
Statutory valuation allowance adjustment	(31,146)	-	(31,146)
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 3,384,094	$ 6,610,520	$ (3,226,426)

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

	2018	2017	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	-	-	-
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(8,714)	(6,363)	(2,351)
CMS RX Reserve	-	-	-
Reserve Transition Adjustment	(271,207)	-	(271,207)
Ordinary DTLs	(279,921)	(6,363)	(273,558)
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(279,921)	(6,363)	(273,558)
Net deferred tax assets/(liabilities)	$ 3,104,173	$ 6,604,157	$ (3,499,984)

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the ordinary portion of the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no ordinary DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from. A statutory valuation allowance has been set up for deferred taxes on future capital loss items, due to uncertainty regarding the timing of their reversal.

The tax reform law enacted on December 22, 2017 (the Tax Reform Law) reduced the statutory federal corporate income tax rate to 21 percent from 35 percent, beginning in 2018. The rate reduction required a remeasurement of the Company's net deferred tax asset. The impact on December 31, 2017 surplus was as follows:

	Surplus Impact
Tax Reform Effect on Operations	$ (5,282,998)
Tax Reform Effect on Deferred Taxes Non-Admitted	880,227
Tax Reform Effect on Unrealized Gains and Losses	-
Total Impact of Tax Reform	$ (4,402,771)

Revisions in 2018 to the Company's prior estimate for the effects of the Tax Reform Law were not material to the financial statements. This completes the Company's accounting related to Tax Reform.

The change in nonadmitted deferred tax assets from December 31, 2017 to 2018 was a decrease of $1,240,511. The change in nonadmitted deferred tax assets from December 31, 2016 to 2017 was a decrease of $1,361,058.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

HCRL fee, change to nonadmitted assets and deferred tax true-ups and tax-exempt interest in 2018.

The Company had no net operating loss carryforwards at December 31, 2018 or 2017.

The following table demonstrates the income tax expense for 2017 and 2018 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2017	36,805,723	(635)	36,805,088
2018	16,036,199	(7,157)	16,029,042
	$ 52,841,922	$ (7,792)	$ 52,834,130

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2018 or 2017.

As of December 31, 2018, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana’s consolidated income tax returns for 2017 and prior years. Humana’s 2018 tax return is under advance review by the IRS under the Compliance Assurance Process. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2018 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2018
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	AMERICAN ELDERCARE, INC.	65-0380198
6	ARCADIAN HEALTH PLAN, INC.	20-1001348
7	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
8	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
9	CARENETWORK, INC.	39-1514846
10	CAREPLUS HEALTH PLANS, INC.	59-2598550
11	CARITEN HEALTH PLAN INC.	62-1579044
12	CHA HMO, INC.	61-1279717
13	CHA SERVICE COMPANY, INC.	61-1279716
14	COMPBENEFITS COMPANY	59-2531815
15	COMPBENEFITS CORPORATION	04-3185995
16	COMPBENEFITS DENTAL, INC.	36-3686002
17	COMPBENEFITS DIRECT, INC.	58-2228851
18	COMPBENEFITS INSURANCE COMPANY	74-2552026
19	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
20	CONTINUCARE CORPORATION	59-2716023
21	CONTINUCARE MEDICAL MANAGEMENT, INC.	65-0791417
22	CONTINUCARE MSO, INC.	65-0780986
23	DEFENSEWEB TECHNOLOGIES, INC.	33-0916248
24	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
25	DENTICARE, INC.	76-0039628
26	EMPHESYS INSURANCE COMPANY	31-0935772
27	EMPHESYS, INC.	61-1237697
28	FAMILY PHYSICIANS OF WINTER PARK, INC.	59-3164234
29	FPG ACQUISITION CORP.	81-3802918
30	FPG ACQUISITION HOLDINGS CORP.	81-3819187
31	FPG HOLDING COMPANY, LLC	32-0505460
32	HARRIS, ROTHENBERG INTERNATIONAL, INC.	27-1649291

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

33	HEALTH VALUE MANAGEMENT, INC.	61-1223418
34	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
35	HUMANA AT HOME (DALLAS), INC.	75-2739333
36	HUMANA AT HOME (HOUSTON), INC.	76-0537878
37	HUMANA AT HOME (MA), INC.	04-3580066
38	HUMANA AT HOME (SAN ANTONIO), INC.	01-0766084
39	HUMANA AT HOME (TLC), INC.	75-2600512
40	HUMANA AT HOME 1, INC.	65-0274594
41	HUMANA AT HOME, INC.	13-4036798
42	HUMANA BEHAVIORAL HEALTH, INC.	75-2043865
43	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
44	HUMANA DENTAL COMPANY	59-1843760
45	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
46	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
47	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
48	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
49	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
50	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
51	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
52	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
53	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632
54	HUMANA HEALTH PLAN, INC.	61-1013183
55	HUMANA HEALTHCARE RESEARCH, INC. (f/k/a COMPREHENSIVE HEALTH INSIGHTS, INC.)	42-1575099
56	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
57	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
58	HUMANA INSURANCE COMPANY	39-1263473
59	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
60	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
61	HUMANA MARKETPOINT, INC.	61-1343508
62	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
63	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
64	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
65	HUMANA MEDICAL PLAN, INC.	61-1103898
66	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
67	HUMANA PHARMACY, INC.	61-1316926
68	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
69	HUMANA VETERANS HEALTHCARE SERVICES, INC.	20-8418853
70	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
71	HUMANADENTAL INSURANCE COMPANY	39-0714280
72	HUMANADENTAL, INC.	61-1364005
73	HUMCO, INC.	61-1239538
74	HUM-e-FL, INC.	61-1383567
75	KANAWHA INSURANCE COMPANY	57-0380426
76	KMG AMERICA CORPORATION	20-1377270
77	MANAGED CARE INDEMNITY, INC.	61-1232669
78	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
79	METCARE OF FLORIDA, INC.	65-0879131

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

80	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
81	PARTNERS IN INTEGRATED CARE, INC.	47-2905609
82	PARTNERS IN PRIMARY CARE (GA), P.C.	83-2624178
83	PARTNERS IN PRIMARY CARE (KS), P.A.	82-2000699
84	PARTNERS IN PRIMARY CARE (NC), P.C.	82-1926920
85	PARTNERS IN PRIMARY CARE, P.A.	47-1161014
86	PHP COMPANIES, INC.	62-1552091
87	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
88	PRESERVATION ON MAIN, INC.	20-1724127
89	PRIMARY CARE HOLDINGS, INC.	46-1225873
90	ROHC, LLC	75-2844854
91	SENIORBRIDGE (NC), INC.	56-2593719
92	SENIORBRIDGE CARE MANAGEMENT, INC.	80-0581269
93	SENIORBRIDGE FAMILY COMPANIES (AZ), INC.	46-0702349
94	SENIORBRIDGE FAMILY COMPANIES (CA), INC.	45-3039782
95	SENIORBRIDGE FAMILY COMPANIES (CT), INC.	27-0452360
96	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
97	SENIORBRIDGE FAMILY COMPANIES (IL), INC.	02-0660212
98	SENIORBRIDGE FAMILY COMPANIES (MD), INC.	81-0557727
99	SENIORBRIDGE FAMILY COMPANIES (MO), INC.	46-0677759
100	SENIORBRIDGE FAMILY COMPANIES (NJ), INC.	36-4484449
101	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
102	SENIORBRIDGE FAMILY COMPANIES (OH), INC.	20-0260501
103	SENIORBRIDGE FAMILY COMPANIES (PA), INC.	38-3643832
104	SENIORBRIDGE FAMILY COMPANIES (VA), INC.	46-0691871
105	TEXAS DENTAL PLANS, INC.	74-2352809
106	THE DENTAL CONCERN, INC.	52-1157181
107	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
108	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
109	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105
110	TRANSCEND INSIGHTS, INC.	80-0072760
111	TRANSCEND POPULATION HEALTH MANAGEMENT, LLC	46-5329373

7. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2018 and 2017 are summarized as follows:

	2018	2017
Balance at January 1,	$ 189,459,246	$ 162,844,891
Benefits incurred and loss adjustment expenses related to		
Current year	1,755,624,658	1,791,436,720
Prior year	(17,862,658)	(16,346,058)
	1,737,762,000	1,775,090,662
Benefits and loss adjustment expenses paid related to		
Current year	1,598,384,131	1,604,832,874
Prior year	157,416,260	143,643,433
	1,755,800,391	1,748,476,307
Balance at December 31,	$ 171,420,855	$ 189,459,246

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

Benefits and loss adjustment expenses payable at December 31, 2017 and 2016 ultimately settled during 2018 and 2017 for $17,862,658 and $16,346,058 less, respectively, than the amounts originally estimated as a result of favorable developments of unpaid claims and claim adjustment expenses principally on Commercial and Medicare operations. These favorable developments were generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. The Company did not record any adjustments to premiums related to prior period claims development.

8. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the Department statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the Department is the lesser of 10% of total surplus, or the greater of net operating gain for the calendar year preceding the dividend or for the 3 calendar years preceding the dividend less dividends paid for the most recent 2 of those calendar years. Based on these restrictions, the Company could have paid a maximum dividend to shareholders of approximately $29,420,000 in 2018 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. As shown in the table below, dividends paid in 2018 were deemed extraordinary as two dividends were paid within 12 months. Extraordinary amounts have been approved by the Department.

		Dividend or Return of Capital Amount		
		Ordinary	Extraordinary	Date Paid
Dividend		$ 4,420,000	$ 77,580,000	April 20, 2018
	Total paid in 2018	$ 4,420,000	$ 77,580,000	
Dividend		$ 2,610,000	$ 22,390,000	May 30, 2017
	Total paid in 2017	$ 2,610,000	$ 22,390,000	

9. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Louisiana has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $57,986,150 or the Company, under the discretion of the Commissioner of the Department, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Louisiana which require a minimum capital and surplus level of $115,972,300 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $252,866,515 and $294,286,121 as of December 31, 2018 and 2017, respectively.

Humana Health Benefit Plan of Louisiana, Inc.
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

10. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $390,802 and $354,545 for the years ended December 31, 2018 and 2017, respectively.

Employees supporting the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2018 and 2017 total allocated expenses associated with these plans were $1,800,792 and $1,870,250, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2018 and 2017 were $192,099,708 and $233,031,341, respectively. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 6, which were $18,093,249 and $48,674,825 for the years ended December 31, 2018 and 2017, respectively. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $43,398,493 and $8,087,234 due to and from Humana at December 31, 2018 and 2017, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

HPS, an affiliated entity, has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in healthcare and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(l) for further consideration of related pharmacy rebates.

The Company received no capital contributions in the years ended December 31, 2018 or 2017.

11. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to three years. Operating lease rental payments charged to expenses for the years ended December 31, 2018 and 2017 was $1,495,380 and $1,549,401, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

Future minimum rental payments required under operating leases as of December 31, 2018, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2019	$	1,595,690
2020		129,322
2021		3,998
2022		-
2023		-
Thereafter		-
Total minimum lease payments	$	1,729,010

12. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $1,637,387,185 and $1,627,942,681 for the years ended December 31, 2018 and 2017, respectively. The loss of the Contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2019, and all product offerings filed with CMS for 2019 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the BBA and BIPA, generally, pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to appropriately document all medical data, including the diagnosis data submitted with claims. In addition, the Company conducts medical record reviews as part of its data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the

internal contract level audits described in more detail below as well as ordinary course reviews of the Company's internal business processes.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the RAPS to diagnoses data from the EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on the Company's results of statutory statements of revenue and expenses, changes in surplus, or cash flows.

CMS and the Office of the Inspector General of Health and Human Services (HHS-OIG) are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for the payment years 2012 and 2014.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2014. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as

each audit is completed. Estimates derived from these results were not material to the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana is studying the Proposed Rule and CMS' underlying analysis contained therein. Humana believes, however, that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and expects to provide substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Humana is also evaluating the potential impact of the Proposed Rule, and any related regulatory, industry or company reactions, all or any of which could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus, or cash flows.

Humana believes that, CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS' final rule release regarding MA and Part D prescription drug benefit program regulations for Contract Year 2015 (referred to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each MA risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has filed a motion for reconsideration related to certain aspects of the Federal District Court's opinion and has simultaneously filed a notice to appeal the decision to the Circuit Court of Appeals.

The Company 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 the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows.

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

b. Legal Proceedings: During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus, and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus, and cash flows, and may also affect the Company's reputation.

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

c. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

d. Securities & Credit Markets Risks: Volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. There is a continuing risk that declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Supplemental Investment Information

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

Of the **Humana Health Benefit Plan of Louisiana, Inc.**
Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436
NAIC Group Code 0119 NAIC Company Code 95642 Employer's ID Number 72-1279235
The Investment risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 3 of the statement of admitted assets, liabilities and surplus. $504,294,189.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	LOUISIANA ST	BONDS	$ 106,721,150	21.16%
2.02	LOUISIANA ST GAS & FUELS TAX R	BONDS	19,731,235	3.91%
2.03	LOUISIANA ST LOCAL GOVT ENVRNM	BONDS	12,079,310	2.40%
2.04	BOSSIER PARISH LA PARISHWIDE S	BONDS	11,802,581	2.34%
2.05	NEW ORLEANS LA	BONDS	11,482,202	2.28%
2.06	SAINT TAMMANY LA PARISHWIDE SC	BONDS	8,425,826	1.67%
2.07	LOUISIANA ST PUBLIC FACS AUTH	BONDS	5,933,453	1.18%
2.08	LOUISIANA ST HIGHWAY IMPT REVE	BONDS	5,773,735	1.14%
2.09	SHREVEPORT LA	BONDS	5,139,940	1.02%
2.10	JOHN DEERE CAPITAL CORP	BONDS	5,028,834	1.00%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 419,694,132	83.22%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	20,574,618	4.08%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	1,477,500	0.29%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	1,890,000	0.37%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	-	0.00%	3.12	P/RP-6	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
4.02	Total admitted assets held in foreign investments.	$ 7,996,627		1.59%
4.03	Foreign-currency-denominated investments.	-		0.00%
4.04	Insurance liabilities denominated in that same foreign currency	-		0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	-	0.00%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
6.01	Country:	$	-	0.00%
6.02	Country:		-	0.00%
	Countries rated NAIC - 2			
6.03	Country:	$	-	0.00%
6.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
6.05	Country:	$	-	0.00%
6.06	Country:		-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1 Issuer	2 NAIC Rating		3	4
10.01	-	-	$	-	0.00%
10.02	-	-		-	0.00%
10.03	-	-		-	0.00%
10.04	-	-		-	0.00%
10.05	-	-		-	0.00%
10.06	-	-		-	0.00%
10.07	-	-		-	0.00%
10.08	-	-		-	0.00%
10.09	-	-		-	0.00%
10.10	-	-		-	0.00%

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]		No [ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.				
11.02	Total admitted assets held in Canadian Investments	$	-		0.00%
11.03	Canadian-currency-denominated investments		-		0.00%
11.04	Canadian-denominated insurance liabilities		-		0.00%
11.05	Unhedged Canadian currency exposure		-		0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ -	0.00%
	Largest 3 investments with contractual sales restrictions		
12.03		-	0.00%
12.04		-	0.00%
12.05		-	0.00%

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

	1 Name of Issuer	2	3
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02	-	$ -	0.00%
16.03	-	-	0.00%
16.04	-	-	0.00%
16.05	-	-	0.00%
16.06	-	-	0.00%
16.07	-	-	0.00%
16.08	-	-	0.00%
16.09	-	-	0.00%
16.10	-	-	0.00%
16.11	-	-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02	-	$ -	0.00%
18.03	-	-	0.00%
18.04	-	-	0.00%
18.05	-	-	0.00%
18.06	-	-	0.00%

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:	**2**	**3**
		$ -	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description **1**	**2**	**3**
19.03	-	$ -	0.00%
19.04	-	-	0.00%
19.05	-	-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2018

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
	1	2	1	2
	Amount	Percentage	Amount	Percentage
1. Bonds				
1.1 U.S. treasury securities	$ -	0.00%	$ -	0.00%
1.2 U.S. government agency obligations (excluding mortgage-backed securities)				
1.21 Issued by U.S. government agencies	-	0.00%	-	0.00%
1.22 Issued by U.S. government sponsored agencies	37,054,572	8.44%	37,054,572	8.44%
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	-	0.00%	-	0.00%
1.4 Securities issued by states, territories, and possessions and political subdivisions in the				
1.41 States, territories and possessions and general obligations	119,014,807	27.11%	119,014,807	27.11%
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	48,454,630	11.04%	48,454,630	11.04%
1.43 Revenue and assessment obligations	72,011,952	16.40%	72,011,952	16.40%
1.44 Industrial development and similar obligations	-	0.00%	-	0.00%
1.5 Mortgage-backed securities (includes residential and commercial MBS)				
1.51 Pass-through securities				
1.511 Issued or guaranteed by GNMA	6,479,209	1.48%	6,479,209	1.48%
1.512 Issued or guaranteed by FNMA and FHLMC	1,762,663	0.40%	1,762,663	0.40%
1.513 All other	-	0.00%	-	0.00%
1.52 CMOs and REMICs				
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	-	0.00%	-	0.00%
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	-	0.00%	-	0.00%
1.523 All others	3,020,792	0.69%	3,020,792	0.69%
2. Other debt and other fixed income securities (excluding short-term)				
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	153,720,662	35.02%	153,720,662	35.02%
2.2 Unaffiliated non-U.S. securities (including Canada)	-	0.00%	-	0.00%
2.3 Affiliated securities	-	0.00%	-	0.00%
3. Equity interests				
3.1 Investments in mutual funds	-	0.00%	-	0.00%
3.2 Preferred stocks				
3.21 Affiliated	-	0.00%	-	0.00%
3.22 Unaffiliated	-	0.00%	-	0.00%
3.3 Publicly traded equity securities (excluding preferred stock)				
3.31 Affiliated	-	0.00%	-	0.00%
3.32 Unaffiliated	-	0.00%	-	0.00%
3.4 Other equity securities				
3.41 Affiliated	-	0.00%	-	0.00%
3.42 Unaffiliated	-	0.00%	-	0.00%
3.5 Other equity interests including tangible personal property under lease				
3.51 Affiliated	-	0.00%	-	0.00%
3.52 Unaffiliated	-	0.00%	-	0.00%
4. Mortgage loans				
4.1 Construction and land development	-	0.00%	-	0.00%
4.2 Agricultural	-	0.00%	-	0.00%
4.3 Single family residential properties	-	0.00%	-	0.00%
4.4 Multifamily residential properties	-	0.00%	-	0.00%
4.5 Commercial loans	-	0.00%	-	0.00%
4.6 Mezzanine real estate loans	-	0.00%	-	0.00%
5. Real estate investments				
5.1 Property occupied by the company	-	0.00%	-	0.00%
5.2 Property held for the production of income (including $ of property acquired in the satisfaction of debt)	-	0.00%	-	0.00%
5.3 Property held for sale (including $ of property acquired in the satisfaction of debt)	-	0.00%	-	0.00%
6. Contract loans	-	0.00%	-	0.00%
7. Derivatives	-	0.00%	-	0.00%
8. Receivables for securities	-	0.00%	-	0.00%
9. Securities Lending	-	0.00%	-	0.00%
10. Cash, cash equivalents and short-term investments	(2,522,953)	(0.58)%	(2,522,953)	(0.58)%
11. Other invested assets	-	0.00%	-	0.00%
12. Total invested assets	$ 438,996,334	100.00%	$ 438,996,334	100.00%

Humana Insurance Company

(a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2020 and 2019

Humana Insurance Company
Index
Statutory Basis of Accounting
December 31, 2020 and 2019

Page

Report of Independent Auditors 1

Financial Statements

Statements of Admitted Assets, Liabilities and Surplus 3
Statements of Revenue and Expenses 4
Statements of Changes in Surplus 5
Statements of Cash Flows 6
Notes to Financial Statements 7

Supplemental Investment Information

Investment Risk Interrogatories 48
Summary Investment Schedule 58

Report of Independent Auditors

To the Board of Directors of Humana Insurance Company

We have audited the accompanying statutory financial statements of Humana Insurance Company, which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2020 and 2019, and the related statutory statements of revenue and expenses and changes in surplus, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the state of Wisconsin. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

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pwc

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2020 and 2019, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin described in Note 2.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements taken as a whole. The supplemental investment risk interrogatories and summary investment schedule (collectively, the "supplemental schedules") of the Company, as of December 31, 2020 and for the year then ended are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the statutory-basis financial statements. The supplemental schedules are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The supplemental schedules have been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental schedules are fairly stated, in all material respects, in relation to the statutory-basis financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 29, 2021

Humana Insurance Company
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Admitted Assets		
Cash and invested assets		
Bonds	$ 4,107,067,395	$ 3,576,873,323
Investment in subsidiaries	742,129,787	675,991,500
Mortgage notes receivable from Humana Inc.	8,550,000	8,550,000
Real estate occupied by the Company	10,899,516	12,321,647
Receivable for securities	35,000	10,000
Short-term investments	167,389,639	629,939,908
Total invested assets	5,036,071,337	4,903,686,378
Cash	126,828,448	58,058,892
Cash equivalents	1,180,710,045	883,095,733
Total cash and invested assets	6,343,609,830	5,844,841,003
Premiums receivable	548,604,973	418,268,039
Investment income due and accrued	24,038,784	26,684,338
Amounts receivable relating to uninsured plans	1,129,286,621	494,935,759
Reinsurance receivable	5,765,945	6,174,460
Health care and other receivables	923,081,452	867,606,543
Current federal income tax recoverable	66,243,478	-
Net deferred tax assets	130,573,948	93,263,946
Electronic data processing equipment and software, less accumulated depreciation of $57,073,508 and $46,614,589 in 2020 and 2019, respectively	38,615,372	46,072,096
Receivable from Humana Inc.	183,694,631	192,687,773
Total admitted assets	$ 9,393,515,034	$ 7,990,533,957
Liabilities		
Benefits and loss adjustment expenses payable	$ 3,291,927,287	$ 2,440,353,699
Aggregate health policy reserves	644,149,128	391,164,583
Aggregate health claim reserves	821,860	740,000
Advance premiums	154,085,273	100,273,263
Accounts payable and accrued expenses	918,816,129	911,059,382
Funds held under reinsurance treaties	8,351,534	6,866,237
Current federal income tax payable	-	10,671,798
Total liabilities	5,018,151,211	3,861,128,962
Surplus		
Common stock, $8.00 par value; 15,000,000 shares authorized; 1,104,167 shares issued and outstanding	8,833,336	8,833,336
Special surplus - projected HCRL fee assessment	-	510,143,497
Paid-in surplus	2,105,092,362	2,105,092,362
Unassigned surplus	2,261,438,125	1,505,335,800
Total surplus	4,375,363,823	4,129,404,995
Total liabilities and surplus	$ 9,393,515,034	$ 7,990,533,957

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Earned premiums, net of reinsurance	$ 28,877,184,688	$ 26,445,947,450
Expenses		
Benefits incurred and loss adjustment expenses	24,380,288,125	22,935,211,175
Selling, general and administrative expenses	3,184,891,087	2,420,160,393
Changes in aggregate health policy reserves	80,887,629	(2,834,924)
Total expenses	27,646,066,841	25,352,536,644
Net underwriting gain	1,231,117,847	1,093,410,806
Net investment income	292,447,541	361,424,418
Net realized capital gains on investments (net of capital gains tax of $19,620,490 and $3,010,673, respectively)	738,848	11,325,866
Net other income (expense)	1,299,783	(1,474,837)
Income before federal income tax expense	1,525,604,019	1,464,686,253
Federal income tax expense	398,875,632	280,022,849
Net income	$ 1,126,728,387	$ 1,184,663,404

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2020 and 2019

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2019	1,104,167	$ 8,833,336	$ 1,106,711	$ 2,085,107,576	$ 1,625,625,257	$ 3,720,672,880
Net income	-	-	-	-	1,184,663,404	1,184,663,404
Projected HCRL fee assessment	-	-	510,143,497	-	(510,143,497)	-
Amortization of gain on reinsurance	-	-	(1,106,711)	-	-	(1,106,711)
Change in net unrealized capital loss, less capital gains tax of $0	-	-	-	-	(121,585,946)	(121,585,946)
Change in net deferred income taxes	-	-	-	-	21,574,734	21,574,734
Change in nonadmitted assets	-	-	-	-	(19,798,152)	(19,798,152)
Forgiveness of payable from Humana Inc.	-	-	-	19,984,786	-	19,984,786
Dividends or return of capital paid	-	-	-	-	(675,000,000)	(675,000,000)
Balances at December 31, 2019	1,104,167	8,833,336	510,143,497	2,105,092,362	1,505,335,800	4,129,404,995
Net income	-	-	-	-	1,126,728,387	1,126,728,387
HCRL fee moratorium	-	-	(510,143,497)	-	510,143,497	-
Change in net unrealized capital gain, less capital gains tax of $0	-	-	-	-	66,297,981	66,297,981
Change in net deferred income taxes	-	-	-	-	42,171,191	42,171,191
Change in nonadmitted assets	-	-	-	-	(39,238,731)	(39,238,731)
Dividends or return of capital paid	-	-	-	-	(950,000,000)	(950,000,000)
Balances at December 31, 2020	1,104,167	$ 8,833,336	$ -	$ 2,105,092,362	$ 2,261,438,125	$ 4,375,363,823

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Cash flows from operations		
Premiums collected, net of reinsurance	$ 28,971,886,654	$ 26,701,434,846
Net investment income received	142,213,600	189,060,289
Benefits paid	(22,495,260,427)	(21,713,676,858)
Selling, general and administrative expenses paid	(4,845,676,344)	(3,658,909,389)
Federal income taxes paid	(495,411,398)	(252,371,627)
Net cash from operations	1,277,752,085	1,265,537,261
Cash flows from investments		
Proceeds from investments sold or matured	1,735,579,294	1,760,563,141
Cost of investments acquired	(2,079,870,427)	(1,590,766,585)
Net cash (used for) from investments	(344,291,133)	169,796,556
Cash flows from financing and miscellaneous sources		
Dividends or returns of capital paid	(950,000,000)	(675,000,000)
Other cash applied	(79,627,354)	(108,557,055)
Net cash used for financing and miscellaneous sources	(1,029,627,354)	(783,557,055)
Net change in cash, cash equivalents and short-term investments	(96,166,400)	651,776,762
Cash, cash equivalents and short-term investments		
Beginning of year	1,571,094,534	919,317,771
End of year	$ 1,474,928,132	$ 1,571,094,533

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

1. Reporting Entity

Humana Insurance Company (the Company), a wholly owned subsidiary of CareNetwork Inc., a wholly owned subsidiary of Humana Inc. (Humana), is a life, accident, and health insurance company domiciled in the state of Wisconsin and is authorized to sell life, accident and health products therein and in 49 states including the District of Columbia and the U.S. Virgin Islands. The Company is subject to regulation by the federal government, the Wisconsin Office of the Commissioner of Insurance (the OCI) and the insurance departments of the states in which it is licensed. State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 8, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 7.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 12(a).

As part of the Company's individual Medicare Advantage products, it also offers Dual Eligible Special Needs (D-SNP) plans. In connection with offering a D-SNP plan in a particular state, the Company is required to enter into a special coordinating contract with the applicable state Medicaid agency.

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the OCI, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(s), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Policy and contract liabilities are reported net of reinsurance ceded amounts and any gains from reinsurance transactions are included as a component of surplus, whereas under GAAP, assets and liabilities related to reinsurance ceded contracts are reported on a gross basis and reinsurance transaction gains are reported as a liability;

viii. Investments in subsidiaries are carried at their underlying statutory equity value with changes in value being recorded directly to surplus, whereas under GAAP, these subsidiaries would be consolidated;

ix. Administrative service fees received from customers on an uninsured basis are deducted from general administrative expenses, whereas under GAAP, these administrative fees are reported as revenue within the income statement;

x. Comprehensive income disclosures required by GAAP are omitted; and

xi. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

xii. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The OCI adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The OCI has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. No deviations from the Codification currently exist.

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL 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 MA 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 HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases the Company's effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021. The annual health insurance industry fee levied on the insurance industry was $15.5 billion in 2020.

The 2020 annual health insurance industry fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. A segregation was recorded within special surplus for the annual health insurance industry fee related to the 2019 data year for the 2020 fee. The 2020 health insurance industry fee was paid September 30, 2020. The impact of the annual health insurance industry fee on the Company's operations as of December 31, 2020 and 2019 were as follows:

	2020	2019
HCRL fee assessment payable	$ -	$ 510,143,497
HCRL fee assessment paid	464,411,417	-
Premium written subject to HCRL 9010 assessment	-	25,663,900,250
Total Adjusted Capital Level before surplus adjustment	4,376,071,991	4,130,039,768
Total Adjusted Capital Level after surplus adjustment	4,376,071,991	3,619,896,271
Authorized Control Level after surplus adjustment	1,079,681,341	1,014,950,193

It is reasonably possible that the HCRL and related regulations, as well as other current or future legislative, judicial or regulatory changes, such as the Families First Coronavirus Response Act (the "Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and other legislative or regulatory action taken in response to COVID-19 including restrictions on Humana's ability to manage its provider network or otherwise operate its business, or restrictions on profitability, including reviews by regulatory bodies that may compare its MA profitability to its non-MA business profitability, or compare the profitability of various products within its MA business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, or increases in regulation of Humana's prescription drug benefit businesses, in the aggregate may have a material adverse effect on Humana's results of operations, (including restricting premiums, enrollment and premium growth in certain products and market segments, restricting Humana's ability to expand into new markets, increasing its medical and operating costs, further lowering its Medicare payment rates and increasing its expenses associated with assessments); its financial position; and its cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the HCRL or declare all or certain portions of the HCRL unconstitutional, create uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

c. Cash, Cash Equivalents and Short-Term Investments: The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Short-term investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. Investments: Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as the 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, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as the 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, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds, cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2020 or December 31, 2019.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2020 or 2019.

For other restricted assets reported in aggregate, the pledged amounts with the OCI and other state departments of insurance were $11,301,477 and $11,038,109, which is 0.12% and 0.14% of gross assets and 0.12% and 0.14% of net admitted assets, at December 31, 2020 and 2019, respectively. These investments, generally U.S. Treasury obligations and money market mutual funds, were on deposit at December 31, 2020 and 2019 to satisfy requirements of regulatory agencies. These assets are included in bonds and cash equivalents in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

e. Fair Value: In accordance with SSAP No. 100R, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

Level 3 Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions

about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2020 or 2019.

The fair value of financial assets carried at fair value at December 31, 2020 and 2019 were as follows:

	Fair Value Measurements at December 31, 2020			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	$ -	$ 222,629	$ -	$ 222,629
Corporate debt securities	-	12,620,988	-	12,620,988
Total invested assets	$ -	$ 12,843,617	$ -	$ 12,843,617

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

	Fair Value Measurements at December 31, 2019			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	$ -	$ 294,400	$ -	$ 294,400
Corporate debt securities	-	15,036,478	-	15,036,478
Total invested assets	$ -	$ 15,330,878	$ -	$ 15,330,878

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2020 and 2019 were as follows:

	December 31, 2020					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 5,652,736,110	$ 5,455,167,079	$ 1,092,956,754	$ 4,559,779,356	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 5,661,286,110	$ 5,463,717,079	$ 1,092,956,754	$ 4,559,779,356	$ 8,550,000	$ -

	December 31, 2019					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 5,163,221,729	$ 5,089,908,964	$ 883,095,733	$ 4,280,125,996	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 5,171,771,729	$ 5,098,458,964	$ 883,095,733	$ 4,280,125,996	$ 8,550,000	$ -

f. Real Estate and Long-Lived Assets: Real estate occupied by the Company is carried at the depreciated cost. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from ten to twenty years. Depreciation expense on real estate occupied by the Company was $1,760,633 and $1,944,995 for the years ended December 31, 2020 and 2019, respectively.

The Company periodically reviews long-lived assets, including property and equipment, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in the Company's operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. The Company recognizes an impairment loss based on the excess of the carrying value over the fair value of the asset. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, the Company periodically reviews the estimated lives of all long-lived assets for reasonableness.

g. Investment in subsidiaries: In accordance with SSAP No. 97, *Investments in Subsidiary, Controlled, and Affiliated Entities,* a replacement of SSAP No. 88 (SSAP No. 97), $742,129,787 and $675,991,500 were admitted as investment in subsidiaries at December 31, 2020 and 2019, respectively. The Company owns 100% of the common stock of Humana Employers Health Plan of Georgia, Inc. (HEHPGA), Humana Insurance Company of Kentucky (HICK), and Humana

Health Benefit Plan of Louisiana, Inc. (HHBPLA). The Company accounts for its investment in subsidiaries using the statutory equity method of accounting.

The Company reports an investment in an insurance subsidiary, HHBPLA, for which the audited statutory equity reflects a departure from the NAIC statutory accounting practices and procedures. The Commissioner of Insurance of the State of Louisiana allowed HHBPLA to admit its $719,533 and $775,406 of furniture and equipment used for Health Maintenance Organization operations in 2020 and 2019, respectively, which is not in accordance with NAIC SSAP. Had HHBPLA not been allowed to admit these balances, their ending surplus at December 31, 2020 and 2019 would have been $344,369,369 and $278,859,450, respectively. The Company's risk-based capital would have not triggered a regulatory event had it not used a prescribed or permitted practice.

h. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other income (expense) in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from 3 to 10 years. Depreciation expense, including that related to the nonadmitted portion, was $26,158,063 and $27,087,238 for the years ended December 31, 2020 and 2019, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements was $2,129,330 and $1,939,589 for the years ended December 31, 2020 and 2019, respectively.

i. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2020 and 2019 DTAs of $18,129,081 and $13,267,892, respectively, were nonadmitted.

j. Earned Premiums: Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the

period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for its membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information 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. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022.

The amount of net premiums written by the Company in 2020 and 2019 that were subject to retrospective rating features were $27,296,362,970 and $24,976,993,090, respectively, or 94.53% and 94.45%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $318,241,471 and $303,393,822 as of December 31, 2020

and 2019, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company recorded the following amounts at December 31, 2020 and 2019 for policyholder rebates:

	2020					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred (recovered)	$ 4,341,122	$ 3,129,358	$ (1,623,507)	$ 5,846,973	$ 55,177,890	$ 61,024,863
Medical loss ratio rebates paid	-	2,837,212	346,527	3,183,739	14,581,350	17,765,089
Medical loss ratio rebates unpaid	4,341,122	449,866	378,026	5,169,014	109,278,818	114,447,832

	2019					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred	$ -	$ (1,255,879)	$ 17,870	$ (1,238,009)	$ 55,369,252	$ 54,131,243
Medical loss ratio rebates paid	-	741,888	1,108,205	1,850,093	-	1,850,093
Medical loss ratio rebates unpaid	-	157,720	2,348,060	2,505,780	68,682,278	71,188,058

The amounts recorded for the medical loss rebates incurred are recorded as a reduction of premium in earned premiums in the accompanying statutory statements of revenue and expenses. The medical loss rebates unpaid are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

There is no impact of any reinsurance assumed or ceded on the medical loss ratio rebate.

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

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as define by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process

and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2020 and 2019:

	2020		2019	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 128,324,320	$ -	$ 3,209,354	$ -
Amounts receivable relating to uninsured plans	-	1,119,108,271	-	482,892,958
Aggregate health policy reserves	(85,986,712)	-	(112,321,409)	-
Accounts payable and accrued expenses	-	(162,274,651)	-	(229,954,566)
Net asset (liability)	$ 42,337,608	$ 956,833,620	$ (109,112,055)	$ 252,938,392

I. **Accounting for the Risk-Sharing Provisions of the Health Care Reform Law:** Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's

commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company risk adjustment data for 2018 and 2019 was selected for audit by HHS. The final assessment from this audit was immaterial to the statutory statements of revenues and expenses.

The temporary risk corridor program applied to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including the Company's small group health plans, were not subject to the risk corridor program. The risk corridor provisions were included to limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received

from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to the Company or require it to refund HHS a portion of the premiums the Company received.

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2020 and 2019:

HCRL Risk Adjustment		
Assets	**2020**	**2019**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 8,452,650	$ 9,396,756
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	226,810	214,067
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	8,877,129	10,956,813
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	12,371,151	11,761,211
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	99,711	119,266

HCRL Risk Corridor		
Assets	**2020**	**2019**
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	51,059,517	-
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 18,112,622	$ -	$ 18,112,622	$ -	$ -	$ -
2015	17,262,854	-	17,262,854	-	-	-
2016	18,717,446	-	18,717,446	-	-	-
Total	$ 54,092,922	$ -	$ 54,092,922	$ -	$ -	$ -

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

government for payments under the risk corridor premium stabilization program established under the HCRL for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, the Company received $51,059,517 from the U.S. Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $51,059,517 payment received from the U.S. Government and $2,552,205 in related fees and expenses are reflected in net premium income and selling, general and administrative expenses, respectively.

A roll-forward of risk corridor assets, gross of any nonadmissions and liability balances by program year, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before Dec 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before Dec 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 -3)	Prior Year Accrued Less Payments (Col 2 -4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
Risk Corridors Program Year	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. 2014											
1. Accrued retrospective premium	-		15,079,217		(15,079,217)		15,079,217		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
b. 2015											
1. Accrued retrospective premium	-		17,262,854		(17,262,854)		17,262,854		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
c. 2016											
1. Accrued retrospective premium	-		18,717,446		(18,717,446)		18,717,446		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
d. Total for Risk Corridors	-	-	51,059,517	-	(51,059,517)	-	51,059,517	-		-	-

Explanations of adjustments

A. Adjustment recorded for additional risk corridor payments received in 2020 that had been previously written off.

The transitional reinsurance program required the Company to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the HCRL in the individual commercial market were eligible for recoveries if individual claims exceed a specified threshold. Accordingly, the Company accounted for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in its statutory statements of revenue and expenses. The Company accounted for contributions made by individual commercial plans compliant with the HCRL, which were

subject to recoveries, as ceded premiums (a reduction of earned premiums) and similarly the Company accounted for any recoveries as ceded benefits (a reduction of benefits incurred and loss adjustment expenses) in its statutory statements of revenue and expenses.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the transitional HCRL reinsurance program as of December 31, 2020 and 2019:

	2020	2019
Assets		
Amounts recoverable for claims paid due to HCRL Reinsurance	$ -	$ -
Amounts recoverable for claims unpaid due to HCRL Reinsurance (Contra Liability)	-	-
Amounts receivable relating to uninsured plans for contributions for HCRL Reinsurance	-	-
Liabilities		
Liabilities for contributions payable due to HCRL Reinsurance – not reported as ceded premium	-	-
Ceded reinsurance premiums payable due to HCRL Reinsurance	-	-
Liabilities for amounts held under uninsured plans contributions for HCRL Reinsurance	-	-
Operations (Revenues & Expenses)		
Ceded reinsurance premiums due to HCRL Reinsurance	-	-
Reinsurance recoveries (income statement) due to HCRL Reinsurance payments or expected payments	-	581,309
HCRL Reinsurance contributions – not reported as ceded premiums	-	-

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	9,396,756		15,847,564		(6,450,808)		6,809,461		A.	358,653	
2. Premium adjustments (payables) (including high risk pool payments)		(10,956,813)		(4,599,391)		(6,357,422)		(1,170,650)	B.		(7,528,072)

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

3. Subtotal ACA Permanent Risk Adjustment Program	9,396,756	(10,956,813)	15,847,564	(4,599,391)	(6,450,808)	(6,357,422)	6,809,461	(1,170,650)		358,653	(7,528,072)
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-		-		-		-			-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance-not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		51,059,517		(51,059,517)		51,059,517		C.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	51,059,517	-	(51,059,517)	-	51,059,517	-		-	-
d. Total for ACA Risk Sharing Provisions	9,396,756	(10,956,813)	66,907,081	(4,599,391)	(57,510,325)	(6,357,422)	57,868,978	(1,170,650)		358,653	(7,528,072)

Explanation for adjustments

A. Adjustments related to updates received from CMS associated with 2019 benefit year and the latest data from Wakely Consulting.

B. Small Group estimate changes for unfinalized years, based on latest data from Wakely Consulting.

C. Adjustment recorded for additional risk corridor payments received in 2020 that had been previously written off.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

Net collections under the 3Rs associated with prior coverage years were $62,307,691 and $(10,957,828) in 2020 and 2019, respectively. The Company collected all reinsurance recoverables relating to prior coverage years in 2018.

m. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 9. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2020, 2019, and 2018:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days After Billing
12/31/2020	$ 865,801,825	$ 865,801,825	$ -	$ -	$ -
9/30/2020	1,168,556,064	1,168,556,064	1,160,387,128	-	-
6/30/2020	1,373,937,740	1,373,937,740	1,362,660,688	10,170,454	-
3/31/2020	1,082,989,376	1,082,989,376	1,058,456,911	24,387,760	-
12/31/2019	857,149,998	857,149,998	852,653,167	-	-
9/30/2019	983,974,614	983,974,614	976,954,193	2,515,299	4,505,122
6/30/2019	1,557,140,947	1,557,140,947	1,538,340,203	4,788,022	13,912,563
3/31/2019	1,105,668,614	1,105,668,614	1,095,342,361	-	10,326,253
12/31/2018	871,791,853	871,791,853	861,944,025	4,597,680	2,749,502
9/30/2018	1,019,941,316	1,019,941,316	1,016,254,784	3,686,532	-
6/30/2018	1,351,608,731	1,351,608,731	1,346,148,031	5,460,700	-
3/31/2018	914,970,239	914,970,239	914,970,239	-	-

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $16,517,875 and $28,534,552 were nonadmitted at December 31, 2020 and 2019, respectively.

n. Risk-Share Agreements: The Company negotiates contractual agreements with group Medicare customers, some of which contain gain sharing provisions in the event the benefit ratio is less than an agreed-upon level. In these agreements, the Company and the customers generally share evenly in the gain. The Company recorded gain share payable of $175,887,987 and $40,715,660 as of December 31, 2020 and 2019, respectively, which is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

o. Benefits Incurred and Loss Adjustment Expenses: Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the

date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $77,622,000 at December 31, 2020 but none were recorded at December 31, 2019. The liability at December 31, 2020 is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

p. Reserves for Life Contracts and Deposit-Type Contracts: The Company waives the deduction of deferred fractional premiums upon death of the insured and holds net level or modified premium reserves on mortality and interest bases that are consistent with statutory guidance. The Company does not return any portion of the final premium for periods beyond the date of death. Surrender values are not promised in excess of the legally computed reserves.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

As of December 31, 2020 and 2019 the Company did not have any life insurance in force for which the gross premiums were less than the net premiums according to the standard valuation set by the OCI, as described in SSAP No. 51, *Life Contracts* (SSAP No. 51). As discussed in Note 9, all non-health insurance business, including all associated reserves, was ceded to Humana Insurance Company of Kentucky (HICK) as of January 1, 2013.

q. Administrative Service Only Contracts (ASO): Administrative services fees cover the processing of claims, offering access to the Company's provider networks and clinical programs and responding to customer service inquiries from members of self-funded groups. Fees from providing administrative services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from Humana to cover catastrophic claims or to limit aggregate annual costs. The Company does not reflect payment of ASO claims in its statutory statements of revenue and expenses.

r. Mortgage Loans: Mortgage loans are current and carried at unpaid principal balances, net of discounts/premiums and valuation allowances. The Company has estimated the book/adjusted carrying value of its mortgage loans, to be $8,550,000 at December 31, 2020 and 2019. This estimate was established using a discounted cash flow method based on rating, maturity and future income when compared to the expected yield for mortgages having similar characteristics. The rating for mortgages in good standing is based on property type, location, market conditions, occupancy, debt service coverage, loan to value, caliber of tenancy, borrower and payment record. Problem mortgages are priced to reflect their monetary value to the Company, considering such things as the degree of default, whether or not the payments are still being made, interest rate, maturity and operating performance of the underlying collateral.

During 2020 and 2019, the maximum and minimum lending rates for mortgage loans were 6.65% at both year ends. At the issuance of a loan, the percentage of loan to value on any one loan does not exceed 100.

s. Nonadmitted Assets: Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, furniture and equipment, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

t. Going Concern Considerations: Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). Based on this evaluation, Management has determined that there is no substantial doubt about the Company's ability to continue as a going concern.

u. Reclassifications: Certain prior year amounts have been reclassified to conform to the 2020 financial statement presentation. These reclassifications have no impact on the Company's reported surplus, net income, or net cash flows.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

v. Subsequent Events: The Company evaluated subsequent events through April 29, 2021, the date these financial statements were issued or available to be issued.

On March 19, 2021, the Company requested to pay a dividend to its parent Humana of $750,000,000, of which, all was extraordinary. The Company received approval to pay the dividend from the OCI on March 29, 2021. On April 20, 2021, the Company paid the $750,000,000 dividend to Humana.

The Company is not aware of any other events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements which may have a material effect on its financial condition.

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2020 and 2019 were as follows:

	2020			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 86,450,865	$ 747,748	$ (91,962)	$ 87,106,651
States, territories and possessions	40,724,739	1,351,861	(129)	42,076,471
Political subdivisions of states, territories and possessions	60,193,948	2,047,422	-	62,241,370
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,426,364,809	65,255,683	(658,855)	1,490,961,637
Industrial and miscellaneous	2,493,333,034	130,020,825	(1,099,566)	2,622,254,293
Hybrid Securities	-	-	-	-
Total bonds	$ 4,107,067,395	$ 199,423,539	$ (1,850,512)	$ 4,304,640,422

	2019			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 49,880,748	$ 146,367	$ (19,267)	$ 50,007,848
States, territories and possessions	82,100,971	1,337,974	(7,230)	83,431,715
Political subdivisions of states, territories and possessions	76,481,989	1,225,540	(8,034)	77,699,495
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,471,704,396	32,996,082	(1,148,248)	1,503,552,230
Industrial and miscellaneous	1,896,705,219	40,483,442	(1,693,862)	1,935,494,799
Hybrid Securities	-	-	-	-
Total bonds	$ 3,576,873,323	$ 76,189,405	$ (2,876,641)	$ 3,650,186,087

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The book/adjusted carrying value and estimated fair value of bonds and short-term investments at December 31, 2020, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 240,243,830	$ 240,781,223
Due after one year through five years	746,017,489	779,558,730
Due after five years through ten years	913,840,824	983,851,894
Due after ten years	576,415,408	602,108,463
Mortgage and asset-backed securities	1,797,939,483	1,865,725,755
	$ 4,274,457,034	$ 4,472,026,065

The detail of realized gains (losses) of bonds for the years ended December 31, 2020 and 2019 were as follows:

	2020	2019
Gross realized gains	$ 24,861,753	$ 17,011,113
Gross realized losses	(4,502,415)	(2,674,574)
Net realized gains	$ 20,359,338	$ 14,336,539

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2020 and 2019 were as follows:

	2020					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 47,281,417	$ (91,962)	$ -	$ -	$ 47,281,417	$ (91,962)
States, territories and possessions	7,304,848	(129)	-	-	7,304,848	(129)
Political subdivisions of states, territories and possessions	-	-	-	-	-	-
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	80,636,584	(658,855)	-	-	80,636,584	(658,855)
Industrial and misc.	222,903,328	(611,678)	114,016,835	(487,888)	336,920,163	(1,099,566)
Total invested assets	$ 358,126,177	$ (1,362,624)	$ 114,016,835	$ (487,888)	$ 472,143,012	$ (1,850,512)

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

	2019					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ 11,573,060	$ (19,267)	$ 11,573,060	$ (19,267)
States, territories and possessions	-	-	13,613,712	(7,230)	13,613,712	(7,230)
Political subdivisions of states, territories and possessions	-	-	11,278,345	(8,034)	11,278,345	(8,034)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	156,178,517	(712,278)	64,880,895	(435,970)	221,059,412	(1,148,248)
Industrial and misc.	85,536,366	(336,295)	326,158,813	(1,357,567)	411,695,179	(1,693,862)
Total invested assets	$ 241,714,883	$ (1,048,573)	$ 427,504,825	$ (1,828,068)	$ 669,219,708	$ (2,876,641)

The unrealized loss from all debt securities was generated from 67 investment positions at December 31, 2020. All issuers of debt securities the Company owns that were trading at an unrealized loss at December 31, 2020 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2020, the Company did not intend to sell any debt securities with an unrealized loss position, and it is not likely that the Company will be required to sell these debt securities before recovery of their amortized cost basis. As a result, the Company believes that the debt securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2020.

Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Reinsurance

The Company reinsures portions of its business through various reinsurance treaties. These treaties protect the Company from sustaining losses above predetermined levels and are included as a reduction of earned premiums in the accompanying statements of revenue and expenses. Although the reinsurer in each case is primarily liable on the insurance ceded, the Company remains liable to the insured whether or not the reinsurer meets its contractual obligations.

In 2020 and 2019, the Company did not commute any ceded reinsurance, nor did it enter into or engage in any agreement that reinsures policies or contracts that were in-force or had existing reserves as of the effective date of such agreements. No write-offs of reinsurance balances occurred in 2020 or 2019. The Company remains obligated for amounts ceded in the event that reinsurers do not meet their obligations.

The Company has a reinsurance contract with an affiliate as noted within Note 9. For the years ended December 31, 2020 and 2019 there were $48,245,098 and $50,534,711 premiums ceded, respectively, related to this contract.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The Company has not entered into any reinsurance agreements in which the reinsurer may unilaterally cancel any reinsurance for reasons other than nonpayment of premiums or other amounts due. The Company does not have any reinsurance agreements in effect in which the amount of losses paid or accrued through December 31, 2020 or 2019 would result in a payment to the reinsurer of amounts which, in the aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premiums collected under the reinsured policies. The Company does not have any reinsurance agreements subject to A-791 risk limiting provisions.

5. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2020 and 2019 were as follows:

	2020		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 154,254,430	$ 31,678	$ 154,286,108
Statutory valuation allowance adjustment	-	(31,678)	(31,678)
Adjusted gross deferred tax assets	154,254,430	-	154,254,430
Deferred tax assets nonadmitted	(18,129,081)	-	(18,129,081)
Subtotal net admitted deferred tax assets	136,125,349	-	136,125,349
Gross deferred tax liabilities	(5,551,401)	-	(5,551,401)
Net admitted deferred tax asset/(liability)	$ 130,573,948	$ -	$ 130,573,948

	2019		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 111,944,692	$ 214,010	$ 112,158,702
Statutory valuation allowance adjustment	-	(214,010)	(214,010)
Adjusted gross deferred tax assets	111,944,692	-	111,944,692
Deferred tax assets nonadmitted	(13,267,892)	-	(13,267,892)
Subtotal net admitted deferred tax assets	98,676,800	-	98,676,800
Gross deferred tax liabilities	(5,412,854)	-	(5,412,854)
Net admitted deferred tax asset/(liability)	$ 93,263,946	$ -	$ 93,263,946

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2020 and 2019 were as follows:

	December 31, 2020		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 126,823,217	$ -	$ 126,823,217
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	3,750,731	-	3,750,731
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	3,750,731
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	630,926,175
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	5,551,401	-	5,551,401
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 136,125,349	$ -	$ 136,125,349

	December 31, 2019		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 90,610,040	$ -	$ 90,610,040
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	2,653,906	-	2,653,906
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	2,653,906
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	598,510,343
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	5,412,854	-	5,412,854
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 98,676,800	$ -	$ 98,676,800

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2020	2019
Ratio percentage used to determine recovery period and threshold limitation amount	390%	393%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 4,206,174,503	$ 3,990,068,953

The Company's tax planning strategies do not include the use of reinsurance.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The significant components of federal income taxes incurred for the years ended December 31, 2020 and 2019 consisted of the following:

	2020	2019
Current year income tax provision	$ 404,289,613	$ 283,808,079
Revisions in prior years' estimated taxes	(5,413,981)	(3,785,230)
Federal income tax expense excluding the tax on realized capital gains and before change in net deferred income taxes	398,875,632	280,022,849
Tax on realized capital gains	19,620,490	3,010,673
Change in net deferred income taxes	(42,171,191)	(21,574,734)
Total statutory income taxes	$ 376,324,931	$ 261,458,788

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2020 and 2019 were as follows:

	2020	2019	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 51,347,974	$ 32,199,087	$ 19,148,887
Advance premiums	6,407,783	4,122,960	2,284,823
Policyholder reserves	234,972	186,900	48,072
Investments	-	-	-
Deferred acquisition costs	30,714,469	24,683,173	6,031,296
Policyholder dividends accrual	-	-	-
Fixed assets	-	-	-
Compensation and benefit accruals	22,884,214	21,648,132	1,236,082
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	3,060,058	2,092,226	967,832
Bad debts	-	2,582,190	(2,582,190)
Accrued litigation	1,646,820	1,562,913	83,907
CMS Rx reserves	23,812,375	20,303,218	3,509,157
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	1,459,228	732,177	727,051
Accrued lease	2,120,779	502,952	1,617,827
Section 197 intangibles	266,567	300,963	(34,396)
Premium rebates MER	8,603,109	-	8,603,109
Provider contracts	1,696,082	1,027,801	668,281
Premium acquisition expense	-	-	-
Gross ordinary DTAs	154,254,430	111,944,692	42,309,738
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(18,129,081)	(13,267,892)	(4,861,189)
Admitted ordinary DTAs	136,125,349	98,676,800	37,448,549
Capital			
Investments	31,678	214,010	(182,332)
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	31,678	214,010	(182,332)
Statutory valuation allowance adjustment	(31,678)	(214,010)	182,332
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 136,125,349	$ 98,676,800	$ 37,448,549

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	(3,160,279)	(3,042,623)	(117,656)
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(72,486)	(78,410)	5,924
Bad debts	(408,785)	-	(408,785)
Reserve transition adjustment	(1,909,851)	(2,291,821)	381,970
Ordinary DTLs	(5,551,401)	(5,412,854)	(138,547)
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(5,551,401)	(5,412,854)	(138,547)
Net deferred tax assets/(liabilities)	$ 130,573,948	$ 93,263,946	$ 37,310,002

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the ordinary portion of the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no ordinary DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from. A statutory valuation allowance has been set up for deferred taxes on future capital loss items, due to uncertainty regarding the timing of their reversal.

The change in nonadmitted deferred tax assets from December 31, 2019 to 2020 was an increase of $4,861,189. The change in nonadmitted deferred tax assets from December 31, 2018 to 2019 was an increase of $2,943,725.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the HCRL fee, dividends received deduction and nonadmitted assets and deferred tax true-ups in 2020.

The Company had no net operating loss carryforwards at December 31, 2020 or 2019.

The following table demonstrates the income tax expense for 2019 and 2020 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2019	$ 278,394,098	$ 3,010,673	$ 281,404,771
2020	404,289,613	19,620,490	423,910,103
	$ 682,683,711	$ 22,631,163	$ 705,314,874

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2020 or 2019.

As of December 31, 2020, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana's consolidated income tax returns for 2017 and prior years. Humana's 2018 and 2019 tax returns are in the post-filing review period under the Compliance Assurance Process (CAP). Humana's 2020 tax return is under advance review by the IRS under CAP. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2020 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2020
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	ARCADIAN HEALTH PLAN, INC.	20-1001348
6	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
7	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
8	CARENETWORK, INC.	39-1514846
9	CAREPLUS HEALTH PLANS, INC.	59-2598550
10	CARITEN HEALTH PLAN INC.	62-1579044
11	CHA HMO, INC.	61-1279717
12	COMPBENEFITS COMPANY	59-2531815
13	COMPBENEFITS CORPORATION	04-3185995
14	COMPBENEFITS DENTAL, INC.	36-3686002

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

15	COMPBENEFITS DIRECT, INC.	58-2228851
16	COMPBENEFITS INSURANCE COMPANY	74-2552026
17	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
18	CONTINUCARE CORPORATION	59-2716023
19	CONTINUCARE MEDICAL MANAGEMENT, INC.	65-0791417
20	CONVIVA HEALTH MANAGEMENT, LLC (f/k/a TRANSCEND POPULATION HEALTH MANAGEMENT, LLC)	46-5329373
21	CONVIVA HEALTH MSO OF TEXAS, INC. (f/k/a PRIMARY CARE HOLDINGS, INC.)	46-1225873
22	CONVIVA MEDICAL CENTER MANAGEMENT OF TEXAS, P.A. (f/k/a PARTNERS IN PRIMARY CARE, P.A.)	47-1161014
23	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
24	DENTICARE, INC.	76-0039628
25	EAGLE RX HOLDCO, INC.	47-1407967
26	EAGLE RX, INC.	47-1416614
27	EDGE HEALTH MSO, INC.	84-2214810
28	EDGE HEALTH, P.C.	84-2752906
29	EMPHESYS INSURANCE COMPANY	31-0935772
30	EMPHESYS, INC.	61-1237697
31	ENCLARA PHARMACIA, INC.	23-3068914
32	FAMILY PHYSICIANS OF WINTER PARK, INC.	59-3164234
33	FPG ACQUISITION CORP.	81-3802918
34	FPG ACQUISITION HOLDINGS CORP.	81-3819187
35	FPG HOLDING COMPANY, LLC	32-0505460
36	GUIDANTRX, INC.	39-1789830
37	HARRIS, ROTHENBERG INTERNATIONAL, INC.	27-1649291
38	HEALTH VALUE MANAGEMENT, INC.	61-1223418
39	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
40	HUMANA AT HOME (DALLAS), INC.	75-2739333
41	HUMANA AT HOME (HOUSTON), INC.	76-0537878
42	HUMANA AT HOME (SAN ANTONIO), INC.	01-0766084
43	HUMANA AT HOME (TLC), INC.	75-2600512
44	HUMANA AT HOME 1, INC.	65-0274594
45	HUMANA AT HOME, INC.	13-4036798
46	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
47	HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.	84-3226630
48	HUMANA BENEFIT PLAN OF TEXAS, INC.	75-2043865
49	HUMANA DENTAL COMPANY	59-1843760
50	HUMANA DIGITAL HEALTH AND ANALYTICS PLATFORM SERVICES, INC.	80-0072760
51	HUMANA DIRECT CONTRACTING ENTITY, INC.	85-3099097
52	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
53	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
54	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
55	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
56	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
57	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
58	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
59	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
60	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

61	HUMANA HEALTH PLAN, INC.	61-1013183
62	HUMANA HEALTHCARE RESEARCH, INC.	42-1575099
63	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
64	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
65	HUMANA INSURANCE COMPANY	39-1263473
66	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
67	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
68	HUMANA MARKETPOINT, INC.	61-1343508
69	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
70	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
71	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
72	HUMANA MEDICAL PLAN, INC.	61-1103898
73	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
74	HUMANA PHARMACY, INC.	61-1316926
75	HUMANA REAL ESTATE COMPANY	20-1724127
76	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
77	HUMANA VETERANS HEALTHCARE SERVICES, INC.	20-8418853
78	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
79	HUMANADENTAL INSURANCE COMPANY	39-0714280
80	HUMANADENTAL, INC.	61-1364005
81	HUMCO, INC.	61-1239538
82	HUM-e-FL, INC.	61-1383567
83	MANAGED CARE INDEMNITY, INC.	61-1232669
84	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
85	METCARE OF FLORIDA, INC.	65-0879131
86	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
87	PARTNERS IN INTEGRATED CARE, INC.	47-2905609
88	PARTNERS IN PRIMARY CARE (GA), P.C.	83-2624178
89	PARTNERS IN PRIMARY CARE (KS), P.A.	30-1236218
90	PARTNERS IN PRIMARY CARE (KS), P.C.	85-0733589
91	PARTNERS IN PRIMARY CARE (MO), P.C.	85-3676937
92	PARTNERS IN PRIMARY CARE (NC), P.C.	82-1926920
93	PARTNERS IN PRIMARY CARE (SC), P.C.	85-3577914
94	PBM HOLDING COMPANY	61-1340806
95	PBM PLUS MAIL SERVICE PHARMACY, LLC	20-2373204
96	PHP COMPANIES, INC.	62-1552091
97	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
98	PRIMARY CARE MANAGEMENT, INC.	85-0858631
99	ROHC, LLC	75-2844854
100	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
101	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
102	TEXAS DENTAL PLANS, INC.	74-2352809
103	THE DENTAL CONCERN, INC.	52-1157181
104	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
105	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
106	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

6. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2020 and 2019 are summarized as follows:

	2020	2019
Balance at January 1,	$ 2,440,353,699	$ 2,202,442,434
Health care receivables	(875,408,931)	(885,945,143)
Balance at January 1, net of health care receivables	1,564,944,768	1,316,497,291
Benefits incurred and loss adjustment expenses related to		
Current year	24,484,225,543	22,968,450,349
Prior year	(103,937,418)	(33,239,174)
	24,380,288,125	22,935,211,175
Benefits and loss adjustment expenses paid related to		
Current year	22,105,141,890	21,417,748,471
Prior year	1,445,302,987	1,269,015,227
	23,550,444,877	22,686,763,698
Balance at December 31,	3,291,927,287	2,440,353,699
Health care receivables	(897,139,271)	(875,408,931)
Balance at December 31, net of health care receivables	$ 2,394,788,016	$ 1,564,944,768

Benefits and loss adjustment expenses payable, net of healthcare receivables, as of December 31, 2019 were $1,564,944,768. As of December 31, 2020, $1,445,302,987 has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $15,704,363 as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been a $103,937,418 favorable prior-year development since December 31, 2019. The decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Included in this decrease, the Company experienced $80,469,233 of favorable prior year claim development on retrospectively rated policies. However, the business to which it relates is subject to premium adjustments.

7. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the OCI statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the OCI is the lesser of 10% of total surplus or net gain from operations from the prior year. All ordinary dividends are limited to available and accumulated surplus funds. Based on these restrictions, the Company could have paid a maximum dividend or return of capital to shareholders of approximately $412,900,000 in 2020 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. Extraordinary amounts have been approved by the OCI.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

		Dividend or Return of Capital Amount		
		Ordinary	**Extraordinary**	**Date Paid**
Dividend		$ 300,000,000	$ -	April 7, 2020
Dividend		-	650,000,000	December 21, 2020
	Total paid in 2020	$ 300,000,000	$ 650,000,000	
Dividend		$ -	$ 575,000,000	April 30, 2019
Dividend		-	100,000,000	December 19, 2018
	Total paid in 2019	$ -	$ 675,000,000	

8. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Wisconsin has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $1,079,681,341 or the Company, under the discretion of the Commissioner of the OCI, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Wisconsin which require a minimum capital and surplus level of $3,879,748,974 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $4,375,363,823 and $4,129,404,995 as of December 31, 2020 and 2019, respectively.

9. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $2,099,339 and $3,158,543 for the years ended December 31, 2020 and 2019, respectively.

Employees of the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2020 and 2019 total allocated expenses associated with these plans were $32,774,049 and $25,328,381, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2020 and 2019 were $(666,086,637) and $(497,630,601), respectively, which are recorded as a charge to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses. These amounts are net of fees received for services provided to wholly owned

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

subsidiaries of Humana whereby the Company provides claims processing, billing and enrollment and other services as required by the subsidiaries. These amounts are allocated to the affiliates using a method that approximates an amount as if the expense had been incurred solely by the affiliates. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 5, which were $433,700,804 and $298,325,325 for the years ended December 31, 2020 and 2019, respectively. These amounts are net of fees received for services provided to wholly owned subsidiaries of Humana whereby the Company provides claims processing, billing and enrollment and other services as required by the subsidiaries. These amounts are allocated to the affiliates using a method that approximates an amount as if the expense had been incurred solely by the affiliates. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $183,694,631 and $192,687,773 due from Humana at December 31, 2020 and 2019, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

In the ordinary course of business, the Company also directly contracts with related parties to provide services that are routine in nature to its members. The administrative services, access fees, and cost of care services provided are determined within each individual agreement. These amounts are included in benefits incurred and loss adjustment expenses as well as selling, general and administrative expenses in the statutory statements of revenue and expenses.

The following table identifies the amount for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2020 and 2019, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliate and Other Related Parties* (SSAP No. 25):

		2020	2019
SeniorBridge and Humana At Home		$ 132,608,792	$ 164,357,710
	Total	$ 132,608,792	$ 164,357,710

In addition to the related parties above, the Company also has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(m) for further consideration of related pharmacy rebates. The Company had $16,940,564,801 and $16,437,891,312 of administrative service and prescription costs in 2020 and 2019, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(k).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $3,828,375,734 and $3,745,299,190 of prescription costs in 2020 and 2019, respectively, with Humana Pharmacy, Inc.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

The Company has an intercompany reinsurance agreement with its subsidiary HICK. Under the terms of the contract, the Company cedes business including all of it group life, specified disease, disability income, and accident insurance business. For the years ended December 31, 2020 and 2019 there were $48,245,098 and $50,534,711 premiums ceded, respectively, related to this agreement.

The Company entered into a mortgage agreement with Humana on property held by the Company effective February 1, 1999, for $8,550,000 plus accrued interest. The note bears interest only at the rate of 6.65%. The principal and accrued interest amounts were originally due and payable to the Company on January 31, 2009, however, the due date was extended to January 31, 2022. The Company carries this note at book value of $8,550,000.

The Company received no capital contributions in the years ended December 31, 2020 or 2019.

Humana forgave $19,984,786 of the Company's tax liability due to Humana as part of the Company's tax sharing agreement during 2019. The portion of the tax balance being forgiven is associated with an issue that was previously subject to IRS Appeals. The forgiveness was accounted for as contributed surplus per SSAP No. 72 *Surplus and Quasi-Reorganizations* (SSAP No. 72).

10. Employee Benefit Plans

The Company's employees are eligible to participate in the Humana Retirement Savings Plan (the Plan), a defined contribution plan, sponsored by Humana. The Plan maintains two accounts, the Savings Account and the Retirement Account. Humana's total contributions paid to the Plan were $233,856,665 and $219,268,247 for the years ended December 31, 2020 and 2019, respectively. Of these contributions, the Company contributed $123,082,595 and $110,527,415 during 2020 and 2019, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses. As of December 31, 2020 and 2019, the fair market value of the Humana Retirement Savings Plan's assets were $6,280,051,531 and $5,344,599,370, respectively.

11. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to six years. Operating lease rental payments charged to expenses for the years ended December 31, 2020 and 2019 were $21,685,077 and $40,170,122, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

In 2020 and 2019 the Company terminated lease agreements early resulting in the recognition of a liability included within accounts payable and accrued expenses within the accompanying statements of admitted assets, liabilities and surplus. The following table includes the leases terminated and the related liability remaining at December 31, 2020 and 2019:

	2020	2019
Tempe Commerce Center	$ 170,098	$ 359,844
Irvine CA KMG Office	48,522	-
Total liability	$ 218,620	$ 359,844

Future minimum rental payments required under operating leases as of December 31, 2020, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2021	$	22,105,613
2022		18,807,609
2023		10,401,301
2024		5,700,696
2025		4,998,834
Thereafter		12,714,834
Total minimum lease payments	$	74,728,887

12. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $26,181,957,434 and $23,670,125,040 for the years ended December 31, 2020 and 2019, respectively. The loss of the Contracts (which are generally renewed annually) or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2021, and all product offerings filed with CMS for 2021 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the BBA and BIPA, generally, pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information 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. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, the Company conducts medical record reviews as part of its data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below as well as ordinary course reviews of the Company's internal business processes.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

CMS is phasing-in the process of calculating risk scores using diagnoses data from the RAPS to diagnoses data from the EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on the Company's results of statutory statements of revenue and expenses, changes in surplus or cash flows.

CMS and the Office of the Inspector General of Health and Human Services (HHS-OIG) are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation (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 RADV Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of the government's traditional fee-for-service Medicare program, or Medicare FFS. The Company refers to the process of accounting for errors in FFS claims as the FFS Adjuster. This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for payment years 2015 and 2014. CMS completed its RADV contract level audit of the 2012 payment year, but has not yet provided the results.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2016. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory

statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana believes that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and has provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus or cash flows.

Humana believes that, CMS's statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS's 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS's final rule release regarding MA and Part D prescription drug benefit program regulations for Contract Year 2015 (referred to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each MA risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

The Company 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 the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

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

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

b. COVID-19: The emergence and spread of the novel coronavirus, or COVID-19, has impacted the Company's business. Beginning in the second half of March 2020, the implementation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity resulted in the temporary deferral of non-essential care and significant reduction in hospital admissions and overall healthcare system utilization during April 2020. Non-COVID utilization then began to increase during May and June 2020 and continued to rebound throughout the third quarter and early in the fourth quarter of 2020. Then, in the latter half of November and accelerating throughout the month of December, the Company experienced a significant increase in COVID-19 admissions in nearly all of the markets in which it operates across the Company's lines of business resulting in higher COVID-19 treatment and testing costs. During this period, the Company also experienced a corresponding decline in non-COVID utilization in all service categories. The impact of this decline in non-COVID utilization more than offset the higher COVID-19 treatment and testing costs during the period. The Company's 2020 results were also impacted by ongoing pandemic relief efforts.

c. Legal Proceedings: During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus and cash flows, and may also affect the Company's reputation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided Humana's legal counsel with an information request concerning Humana's Medicare Part C risk adjustment practices. The request relates to Humana's oversight and submission of risk adjustment data generated by providers in its MA network, as well as to its business and compliance practices related to risk adjustment data generated by its providers and by Humana, including medical record reviews conducted as part of its data and payment accuracy compliance efforts, the use of health and well-being assessments, and fraud detection efforts. Humana believes that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of MA plans, providers and vendors. Humana continues to cooperate with the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned *United States of America ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by Humana in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by it under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. Humana takes seriously its obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations since the transfer to the Western District of Kentucky. Humana has substantially completed

discovery with the relator who has pursued the matter on behalf of the United States following its unsealing, and expects the Court to consider its motion for summary judgment.

d. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

e. Securities & Credit Markets Risks: Ongoing volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or credit related impairments may be recorded in future periods.

f. Penn Treaty: Penn Treaty is a financially distressed unaffiliated long-term care insurance company. On March 1, 2017, the Pennsylvania Commonwealth Court approved the liquidation of Penn Treaty. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, the Company may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as the Company. This court ruling triggered a guaranty fund assessment for the Company in the first quarter of 2017. Based on current information, the assessment is estimated at approximately $26,032,041 with a remaining unpaid balance as of December 31, 2020 of $8,132,296 included in accounts payable and accrued expenses in the accompanying statements of admitted assets, liabilities and surplus. The Company has also recognized an asset for premium tax credits associated with the assessment at December 31, 2020 and 2019 of $10,174,786 and $12,463,679, respectively, which are expected to be realized over the next 20 years. While the ultimate payment timing and associated recovery is currently unknown, the Company anticipates that the majority of the assessments will be paid within the next 5 years.

The below table reconciles the asset for premium tax credits associated with the assessment at December 31, 2019 to those reported at December 31, 2020.

a.) Assets recognized from paid and accrued premium tax offsets and policy surcharges prior year-end	$	12,463,679
b.) Decreases current year:		
Credits Used		2,203,030
Misc. Adjustments		85,863
c.) Increases current year:		-
d.) Assets recognized from paid and accrued premium tax offsets and policy surcharges current year-end	$	10,174,786

Discount rate applied: 3.50%

The Undiscounted and Discounted Amount of the Guaranty Fund assessments and Related Assets by Insolvency:

Name of the Insolvency	Guaranty Fund Assessment		Related Assets	
	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty	$ 36,965,498	$ 26,032,041	$ 28,063,537	$ 10,174,786

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2020 and 2019

Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency:

	Payables			Recoverables		
Name of the Insolvency	Number of Jurisdictions	Range of Years	Weighted Average Number of Years	Number of Jurisdictions	Range of Years	Weighted Average Number of Years
Penn Treaty	50 states	1 to 70 years	11.96 years	39 states	1 to 20 years	8.1 years

13. Uninsured Plans

Information for the year ended December 31, 2020 regarding the profitability of ASO plans and the uninsured portion of partially insured plans for which the Company provides administrative services were as follows:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	$ (1,827,815)	$ (7,967,010)	$ (9,794,825)
Total net other income or expenses (including interest paid to or received from plans)	(1,342)	(5,848)	(7,190)
Net gain or (loss) from operations	$ (1,829,157)	$ (7,972,858)	$ (9,802,015)
Total claim payment volume	103,403,274	450,710,146	554,113,420

As of December 31, 2020, the Company has recorded a receivable from CMS of $1,119,108,271 related to the cost share and reinsurance components of administered Medicare products and a receivable from ASO customers of $10,178,350. The Company has recorded receivables from the following payors whose account balance are greater than 10% of the Company's accounts receivable from uninsured accident and health plans or $10,000:

	2020
Maricopa Community College	$ 1,103,885
Excela Health	623,523

	2019
Advocate Health Care APP	$ 2,653,200
Excela Health	1,125,444
Maricopa Community College	1,116,047
Baptist Health Floyd	921,229

Supplemental Investment Information

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

Of the **Humana Insurance Company**
Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436

NAIC Group Code 0119 NAIC Company Code 73288 Employer's ID Number 39-1263473
The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 3 of the statement of admitted assets, liabilities and surplus. $9,393,515,033.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	Federal National Mortgage Association	MBS	$ 631,040,752	6.72%
2.02	Freddie Mac	MBS CMO	320,988,597	3.42%
2.03	Apple Inc.	Bonds Commercial Paper	104,986,428	1.12%
2.04	Federal Home Loan Banks	Bonds	95,996,944	1.02%
2.05	Citigroup Inc.	Bonds	51,735,812	0.55%
2.06	Bank of America Corporation	Bonds	49,957,539	0.53%
2.07	Wells Fargo & Company	Bonds	46,867,597	0.50%
2.08	Cd 2017-Cd3	MBS	46,654,855	0.50%
2.09	Dormitory Authority of the State of New York	MBS	45,179,560	0.48%
2.10	Morgan Stanley	Bonds	45,154,392	0.48%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 3,883,313,100	41.34%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	944,329,099	10.05%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	163,788,850	1.74%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	19,412,165	0.21%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	222,629	0.00%	3.12	P/RP-6	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?		Yes [ ]	No [X]
4.02	Total admitted assets held in foreign investments.	$	308,962,094	3.29%
4.03	Foreign-currency-denominated investments.		-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency		-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	308,962,094	3.29%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

				1	2
	Countries rated NAIC - 1:				
6.01	Country:	Cayman Islands	$	229,061,673	2.44%
6.02	Country:	Switzerland		20,570,000	0.22%
	Countries rated NAIC - 2				
6.03	Country:		$	-	0.00%
6.04	Country:			-	0.00%
	Countries rated NAIC - 3 or below				
6.05	Country:		$	-	0.00%
6.06	Country:			-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1	2		3	4
	Issuer	**NAIC Rating**			
10.01	Park Avenue Institutional Advisers CLO Ltd 2017-1	1FE	$	18,850,000	0.20%
10.02	Credit Suisse Group AG	2FE		15,840,000	0.17%
10.03	CBAM 2017-1 Ltd.	1FE		14,768,160	0.16%
10.04	Carlyle Global Market Strategies CLO 2014-3-R Ltd	1FE		14,016,402	0.15%
10.05	Neuberger Berman Loan Advisers Clo 26 Ltd.	1FE		13,753,211	0.15%
10.06	Mitsubishi UFJ Financial Group Inc.	1FE		13,534,626	0.14%
10.07	Tiaa Clo III Ltd	1FE		12,880,000	0.14%
10.08	Palmer Square CLO 2018-2 Ltd	1FE		12,674,438	0.13%
10.09	Carlyle US CLO 2017-4 Ltd	1FE		12,500,000	0.13%
10.10	ANZ New Zealand (Int'l) Limited	1FE		11,016,583	0.12%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.

11.02	Total admitted assets held in Canadian Investments	$	-	0.00%
11.03	Canadian-currency-denominated investments		-	0.00%
11.04	Canadian-denominated insurance liabilities		-	0.00%
11.05	Unhedged Canadian currency exposure		-	0.00%

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ -	0.00%
	Largest 3 investments with contractual sales restrictions		
12.03		-	0.00%
12.04		-	0.00%
12.05		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]
	If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.		

	1 Name of Issuer	2	3
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]
	If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.		

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06	JPMorgan Trust II - JPMorgan U.S. Treasury Plus Money Market Fund	$ 255,138,934	$ 255,138,934	$ -
14.07	First American Funds Inc. - Treasury Obligations Fund	188,666,582	188,666,582	-
14.08	JP Morgan	170,013,151	170,013,151	-
14.09	Fidelity Colchester Street Trust - Treasury Portfolio	136,052	136,052	-
14.10	BlackRock Liquidity Funds - Treasury Trust Fund	77,778	77,778	-
14.11	Wells Fargo Funds Trust - Treasury Plus Money Market Fund	55,009	55,009	-
14.12	BlackRock Liquidity Funds - T-Fund	26,882	26,882	-
14.13		-	-	-
14.14		-	-	-
14.15		-	-	-

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ -	0.00%
16.03		-	0.00%
16.04		-	0.00%
16.05		-	0.00%
16.06		-	0.00%
16.07		-	0.00%
16.08		-	0.00%
16.09		-	0.00%
16.10		-	0.00%
16.11		-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ -	0.00%
18.03		-	0.00%
18.04		-	0.00%
18.05		-	0.00%
18.06		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:		**2**	**3**
		$	-	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description			
	1		**2**	**3**
19.03	-	$	-	0.00%
19.04	-		-	0.00%
19.05	0		-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Insurance Company
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2020

		Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
		1	2	1	2
		Amount	Percentage	Amount	Percentage
1. Long-Term Bonds					
1.01	U.S. governments	$ 86,450,865	1.36%	$ 86,450,865	1.36%
1.02	All other governments	-	0.00%	-	0.00%
1.03	U.S. states, territories and possessions, etc. guaranteed	40,724,739	0.64%	40,724,739	0.64%
1.04	U.S. political subdivisions of states, territories, and possessions, guaranteed	60,193,948	0.95%	60,193,948	0.95%
1.05	U.S. special revenue and special assessment obligations, etc. non-guaranteed	1,426,364,809	22.49%	1,426,364,809	22.49%
1.06	Industrial and miscellaneous	2,493,333,034	39.30%	2,493,333,034	39.30%
1.07	Hybrid securities	-	0.00%	-	0.00%
1.08	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
1.09	SVO identified funds	-	0.00%	-	0.00%
1.10	Unaffiliated Bank loans	-	0.00%	-	0.00%
1.11	Total long-term bonds	4,107,067,395	64.74%	4,107,067,395	64.74%
2. Preferred stocks					
2.01	Industrial and miscellaneous (Unaffiliated)	-	0.00%	-	0.00%
2.02	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
2.03	Total preferred stocks	-	0.00%	-	0.00%
3. Common stocks					
3.01	Industrial and miscellaneous Publicly traded (Unaffiliated)	-	0.00%	-	0.00%
3.02	Industrial and miscellaneous Other (Unaffiliated)	-	0.00%	-	0.00%
3.03	Parent, subsidiaries and affiliates Publicly traded	-	0.00%	-	0.00%
3.04	Parent, subsidiaries and affiliates Other	742,129,787	11.70%	742,129,787	11.70%
3.05	Mutual funds	-	0.00%	-	0.00%
3.06	Unit investment trusts	-	0.00%	-	0.00%
3.07	Closed-end funds	-	0.00%	-	0.00%
3.08	Total common stocks	742,129,787	11.70%	742,129,787	11.70%
4. Mortgage loans					
4.01	Farm mortgages	-	0.00%	-	0.00%
4.02	Residential mortgages	-	0.00%	-	0.00%
4.03	Commercial mortgages	8,550,000	0.13%	8,550,000	0.13%
4.04	Mezzanine real estate loans	-	0.00%	-	0.00%
4.05	Total valuation allowance	-	0.00%	-	0.00%
4.06	Total mortgage loans	8,550,000	0.13%	8,550,000	0.13%
5. Real estate					
5.01	Properties occupied by company	10,899,516	0.17%	10,899,516	0.17%
5.02	Properties held for production of income	-	0.00%	-	0.00%
5.03	Properties held for sale	-	0.00%	-	0.00%
5.04	Total real estate	10,899,516	0.17%	10,899,516	0.17%
6. Cash, cash equivalents and short-term investments					
6.01	Cash	126,828,448	2.00%	126,828,448	2.00%
6.02	Cash equivalents	1,180,710,045	18.61%	1,180,710,045	18.61%
6.03	Short-term investments	167,389,639	2.64%	167,389,639	2.64%
6.04	Total cash, cash equivalents and short-term investments	1,474,928,132	23.25%	1,474,928,132	23.25%
7. Contract loans		-	0.00%	-	0.00%
8. Derivatives		-	0.00%	-	0.00%
9. Other invested assets		-	0.00%	-	0.00%
10. Receivables for securities		35,000	0.00%	35,000	0.00%
11. Securities Lending		-	0.00%	-	0.00%
12. Other invested assets		-	0.00%	-	0.00%
13.	Total invested assets	$ 6,343,609,830	100.00%	$ 6,343,609,830	100.00%

Humana Insurance Company

(a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2019 and 2018

Humana Insurance Company
Index
Statutory Basis of Accounting
December 31, 2019 and 2018

Page

Report of Independent Auditors 1

Financial Statements

Statements of Admitted Assets, Liabilities and Surplus 3

Statements of Revenue and Expenses 4

Statements of Changes in Surplus 5

Statements of Cash Flows 6

Notes to Financial Statements 7

Supplemental Investment Information

Investment Risk Interrogatories 48

Summary Investment Schedule 58

Report of Independent Auditors

To the Board of Directors of Humana Insurance Company

We have audited the accompanying statutory financial statements of Humana Insurance Company, which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2019 and 2018, and the related statutory statements of revenue and expenses and changes in surplus, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

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pwc

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2019 and 2018, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2019 and 2018, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin described in Note 2.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the financial statements taken as a whole. The supplemental investment risk interrogatories and summary investment schedule (collectively, the "supplemental schedules") of the Company, as of December 31, 2019 and for the year then ended, are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and is not a required part of the financial statements. The information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 30, 2020

Humana Insurance Company
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2019 and 2018

	2019	2018
Admitted Assets		
Cash and invested assets		
Bonds	$ 3,576,873,323	$ 3,547,216,138
Investment in subsidiaries	675,991,500	804,849,178
Mortgage notes receivable from Humana Inc.	8,550,000	8,550,000
Real estate occupied by the Company	12,321,647	13,576,713
Receivable for securities	10,000	-
Short-term investments	629,939,908	217,858,209
Total invested assets	4,903,686,378	4,592,050,238
Cash and cash equivalents	941,154,625	701,459,562
Total cash and invested assets	5,844,841,003	5,293,509,800
Premiums receivable	418,268,039	604,232,186
Investment income due and accrued	26,684,338	30,920,611
Amounts receivable relating to uninsured plans	494,935,759	151,386,173
Reinsurance receivable	6,174,460	23,210,968
Health care and other receivables	867,606,543	934,936,898
Current federal income tax recoverable	-	1,767,208
Net deferred tax assets	93,263,946	74,632,937
Electronic data processing equipment and software, less accumulated depreciation of $46,614,589 and $38,975,797 in 2019 and 2018, respectively	46,072,096	54,206,496
Receivable from Humana Inc.	192,687,773	64,578,016
Total admitted assets	$ 7,990,533,957	$ 7,233,381,293
Liabilities		
Benefits and loss adjustment expenses payable	$ 2,440,353,699	$ 2,202,442,434
Aggregate health policy reserves	391,164,583	298,437,261
Aggregate health claim reserves	740,000	2,533,000
Advance premiums	100,273,263	112,415,528
Accounts payable and accrued expenses	911,059,382	883,501,355
Funds held under reinsurance treaties	6,866,237	13,378,835
Current federal income tax payable	10,671,798	-
Total liabilities	3,861,128,962	3,512,708,413
Surplus		
Common stock, $8 par value; 15,000,000 shares authorized; 1,104,167 shares issued and outstanding	8,833,336	8,833,336
Gain on Reinsurance	-	1,106,711
Special surplus - projected HCRL fee assessment	510,143,497	-
Paid-in surplus	2,105,092,362	2,085,107,576
Unassigned surplus	1,505,335,800	1,625,625,257
Total surplus	4,129,404,995	3,720,672,880
Total liabilities and surplus	$ 7,990,533,957	$ 7,233,381,293

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2019 and 2018

	2019	2018
Earned premiums, net of reinsurance	$ 26,445,947,450	$ 24,820,038,571
Expenses		
Benefits incurred and loss adjustment expenses	22,935,211,175	21,088,174,398
Selling, general and administrative expenses	2,420,160,393	2,717,236,520
Changes in aggregate health policy reserves	(2,834,924)	994,315
Total expenses	25,352,536,644	23,806,405,233
Net underwriting gain	1,093,410,806	1,013,633,338
Net investment income	361,424,418	375,241,539
Net realized capital gains on investments (net of capital gains tax of $3,010,673 and $1,989,160, respectively)	11,325,866	7,483,029
Net other expense	(1,474,837)	(2,132,160)
Income before federal income tax expense	1,464,686,253	1,394,225,746
Federal income tax expense	280,022,849	254,188,788
Net income	$ 1,184,663,404	$ 1,140,036,958

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2019 and 2018

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2018	1,104,167	$ 8,833,336	$ 474,068,972	$ 2,086,790,088	$ 1,614,820,944	$ 4,184,513,340
Net income	-	-	-	-	1,140,036,958	1,140,036,958
HCRL fee moratorium	-	-	(474,068,972)	-	474,068,972	-
Gain on reinsurance	-	-	1,106,711	-	-	1,106,711
Change in net unrealized capital loss, less capital gains tax of $0	-	-	-	-	(171,565,548)	(171,565,548)
Change in net deferred income taxes	-	-	-	-	(50,745,131)	(50,745,131)
Change in nonadmitted assets	-	-	-	-	(55,990,938)	(55,990,938)
Other	-	-	-	(1,682,512)	-	(1,682,512)
Dividends or return of capital paid	-	-	-	-	(1,325,000,000)	(1,325,000,000)
Balances at December 31, 2018	1,104,167	8,833,336	1,106,711	2,085,107,576	1,625,625,257	3,720,672,880
Net income	-	-	-	-	1,184,663,404	1,184,663,404
Projected HCRL fee assessment	-	-	510,143,497	-	(510,143,497)	-
Amortization of gain on reinsurance	-	-	(1,106,711)	-	-	(1,106,711)
Change in net unrealized capital loss, less capital gains tax of $0	-	-	-	-	(121,585,946)	(121,585,946)
Change in net deferred income taxes	-	-	-	-	21,574,734	21,574,734
Change in nonadmitted assets	-	-	-	-	(19,798,152)	(19,798,152)
Forgiveness of payable from Humana Inc.	-	-	-	19,984,786	-	19,984,786
Dividends or return of capital paid	-	-	-	-	(675,000,000)	(675,000,000)
Balances at December 31, 2019	1,104,167	$ 8,833,336	$ 510,143,497	$ 2,105,092,362	$ 1,505,335,800	$ 4,129,404,995

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2019 and 2018

	2019	2018
Cash flows from operations		
Premiums collected, net of reinsurance	$ 26,701,434,846	$ 24,565,587,944
Net investment income received	189,060,289	253,484,760
Benefits paid	(21,713,676,858)	(20,163,726,464)
Selling, general and administrative expenses paid	(3,658,909,389)	(4,050,218,668)
Federal income taxes paid	(252,371,627)	(333,698,015)
Net cash from operations	1,265,537,261	271,429,557
Cash flows from investments		
Proceeds from investments sold or matured	1,760,563,141	1,097,977,605
Cost of investments acquired	(1,590,766,585)	(1,949,262,605)
Net cash from (used for) investments	169,796,556	(851,285,000)
Cash flows from financing and miscellaneous sources		
Dividends or returns of capital paid	(675,000,000)	(1,325,000,000)
Other cash (applied) provided	(108,557,055)	117,953,282
Net cash used for financing and miscellaneous sources	(783,557,055)	(1,207,046,718)
Net change in cash, cash equivalents and short-term investments	651,776,762	(1,786,902,161)
Cash, cash equivalents and short-term investments		
Beginning of year	919,317,771	2,706,219,932
End of year	$ 1,571,094,533	$ 919,317,771

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

1. Reporting Entity

Humana Insurance Company (the Company), a wholly owned subsidiary of CareNetwork Inc., a wholly owned subsidiary of Humana Inc. (Humana), is a life, accident, and health insurance company domiciled in the state of Wisconsin and is authorized to sell life, accident and health products therein and in 49 states including the District of Columbia. The Company is subject to regulation by the federal government, the Wisconsin Office of the Commissioner of Insurance (the OCI) and the insurance departments of the states in which it is licensed. State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 8, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 7.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 12(a).

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately materially differ from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the OCI, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(t), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Policy and contract liabilities are reported net of reinsurance ceded amounts and any gains from reinsurance transactions are included as a component of surplus, whereas under GAAP, assets and liabilities related to reinsurance ceded contracts are reported on a gross basis and reinsurance transaction gains are reported as a liability;

viii. Investments in subsidiaries are carried at their underlying statutory equity value with changes in value being recorded directly to surplus, whereas under GAAP, these subsidiaries would be consolidated;

ix. Administrative service fees received from customers on an uninsured basis are deducted from general administrative expenses, whereas under GAAP, these administrative fees are reported as revenue within the income statement;

x. Comprehensive income disclosures required by GAAP are omitted; and

xi. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

xii. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The OCI adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The OCI has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. No deviations from the Codification currently exist.

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL 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 (MA) 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 HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee was suspended in 2019, but will resume for calendar year 2020, not be deductible for income tax purposes, and significantly increase the Company's effective tax rate. The annual health insurance industry fee levied on the insurance industry was $14.3 billion in 2018. Under current law, the health industry fee will be permanently repealed beginning in calendar year 2021.

It is reasonably possible that the HCRL and related regulations, as well as other current or future legislative, judicial or regulatory changes, including restrictions on Humana's ability to manage its provider network or otherwise operate its business, or restrictions on profitability, including reviews by regulatory bodies that may compare its MA profitability to its non-MA business profitability, or compare the profitability of various products within its MA business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, or increases in regulation of Humana's prescription drug benefit businesses, in the aggregate may have a material adverse effect on Humana's results of operations, (including restricting premiums, enrollment and premium growth in certain products and market segments, restricting Humana's ability to expand into new markets, increasing its medical and operating costs, further lowering its Medicare payment rates and increasing its expenses associated with assessments); its financial position; and its cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the HCRL or declare all or certain portions of the HCRL unconstitutional, creates uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

c. Cash, Cash Equivalents and Short-Term Investments: The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Short-term investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. Investments: Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is

considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as 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, changes in fair value of the security after the balance sheet date, and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as 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, changes in fair value of the security after the balance sheet date, and cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2019 or December 31, 2018.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2019 or 2018.

For other restricted assets reported in aggregate, the pledged amounts with the OCI and other state departments of insurance were $11,038,109 and $11,003,049, which is 0.14% and 0.15% of gross assets and 0.14% and 0.15% of net admitted assets, at December 31, 2019 and 2018, respectively.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

e. Fair Value: In accordance with SSAP No. 100, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2019 or 2018.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The fair value of financial assets carried at fair value at December 31, 2019 and 2018 were as follows:

	Fair Value Measurements at December 31, 2019			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	-	294,400	-	294,400
Corporate debt securities	-	15,036,478	-	15,036,478
Total invested assets	$ -	$ 15,330,878	$ -	$ 15,330,878

	Fair Value Measurements at December 31, 2018			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	-	347,662	-	347,662
Corporate debt securities	-	136,046,067	-	136,046,067
Total invested assets	$ -	$ 136,393,729	$ -	$ 136,393,729

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2019 and 2018 were as follows:

	December 31, 2019					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 5,163,221,729	$ 5,089,908,964	$ 883,095,733	$ 4,280,125,996	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 5,171,771,729	$ 5,098,458,964	$ 883,095,733	$ 4,280,125,996	$ 8,550,000	$ -

	December 31, 2018					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 4,278,164,081	$ 4,344,265,880	$ 579,191,533	$ 3,698,972,548	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 4,286,714,081	$ 4,352,815,880	$ 579,191,533	$ 3,698,972,548	$ 8,550,000	$ -

The Company reports transfers between fair value hierarchy levels at the end of the reporting period. There were no material transfers between the fair value hierarchy levels during 2019 or 2018.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

f. Real Estate and Long-Lived Assets: Real estate occupied by the Company is carried at the depreciated cost. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from ten to twenty years. Depreciation expense on real estate occupied by the Company was $1,944,995 and $1,671,048 for the years ended December 31, 2019 and 2018, respectively.

The Company periodically reviews long-lived assets, including property and equipment, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in the Company's operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. The Company recognizes an impairment loss based on the excess of the carrying value over the fair value of the asset. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, the Company periodically reviews the estimated lives of all long-lived assets for reasonableness.

g. Statutory Deposits: Investments, generally U.S. Treasury obligations, were on deposit at December 31, 2019 and 2018 to satisfy requirements of regulatory agencies. These assets are included in bonds in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

h. Investment in subsidiaries: In accordance with SSAP No. 97, *Investments in Subsidiary, Controlled, and Affiliated Entities,* a replacement of SSAP No. 88 (SSAP No. 97), $675,991,500 and $804,849,178 were admitted as investment in subsidiaries at December 31, 2019 and 2018, respectively. The Company owns 100% of the common stock of Humana Employers Health Plan of Georgia, Inc. (HEHPGA), Humana Insurance Company of Kentucky (HICK), and Humana Health Benefit Plan of Louisiana, Inc. (HHBPLA). The Company accounts for its investment in subsidiaries using the statutory equity method of accounting.

The Company reports an investment in an insurance subsidiary, HHBPLA, for which the audited statutory equity reflects a departure from the NAIC statutory accounting practices and procedures. The Commissioner of Insurance of the State of Louisiana allowed the Company to admit its $775,406 and $1,209,176 of furniture and equipment used for Health Maintenance Organization operations in 2019 and 2018, respectively, which is not in accordance with NAIC SSAP. Had HHBPLA not been allowed to admit these balances, the Company's ending surplus at December 31, 2019 and 2018 would have been $4,128,629,589 and $3,719,463,704, respectively. The Company's risk-based capital would have not triggered a regulatory event had it not used a prescribed or permitted practice.

i. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other expense in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from three to ten years. Depreciation expense, including that related to the nonadmitted portion, was $27,087,238 and $23,084,740 for the years ended December 31, 2019 and 2018, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements was $1,939,589 and $2,130,306 for the years ended December 31, 2019 and 2018, respectively.

j. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of

the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2019 and 2018 DTAs of $13,267,892 and $10,324,167, respectively, were nonadmitted.

k. Earned Premiums: Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally, pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

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. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score was calculated from claims data submitted through EDS. CMS will increase that percentage to 50% in 2020 and has proposed to increase that percentage to 75% in 2021.

The amount of net premiums written by the Company in 2019 and 2018 that were subject to retrospective rating features were $24,976,993,090 and $23,661,513,742, respectively, or 94.45% and 95.33%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $303,393,822 and $508,696,324 as of December 31, 2019 and 2018, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company recorded the following amounts at December 31, 2019 and 2018 for policyholder rebates:

	2019					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred (recovered)	$ -	$ (1,255,879)	$ 17,870	$ (1,238,009)	$ 55,369,252	$ 54,131,243
Medical loss ratio rebates paid	-	741,888	1,108,205	1,850,093	-	1,850,093
Medical loss ratio rebates unpaid	-	157,720	2,348,060	2,505,780	68,682,278	71,188,058

	2018					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred	$ 2,446,421	$ 2,279,187	$ 3,858,865	$ 8,584,473	$ 11,017,026	$ 19,601,499
Medical loss ratio rebates paid	8,164,201	2,017,801	1,698,563	11,880,565	-	11,880,565
Medical loss ratio rebates unpaid	-	2,155,487	3,438,395	5,593,882	13,313,026	18,906,908

The amounts recorded for the medical loss rebates incurred are recorded as a reduction of premium in earned premiums in the accompanying statutory statements of revenue and expenses. The medical loss rebates unpaid are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus. Medical loss ratio rebates that were accrued at December 31, 2018, were ultimately settled during 2019 for $3,743,789 less than the amounts originally estimated.

There is no impact of any reinsurance assumed or ceded on the medical loss ratio rebate.

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

The risk corridor provisions compare costs targeted in the Company's 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 the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately nine months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2019 and 2018:

	2019		2018	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 3,209,354	$ -	$ 1,301,107	$ -
Amounts receivable relating to uninsured plans	-	482,892,958	-	132,885,205
Aggregate health policy reserves	(112,321,409)	-	(122,601,698)	-
Accounts payable and accrued expenses	-	(229,954,566)	-	(318,043,557)
Net (liability) asset	$ (109,112,055)	$ 252,938,392	$ (121,300,591)	$ (185,158,352)

m. Accounting for the Risk-Sharing Provisions of the Health Care Reform Law: Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company's risk adjustment data for 2018 was selected for audit by HHS.

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

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2019 and 2018:

HCRL Risk Adjustment		
Assets	**2019**	**2018**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 9,396,756	$ 479,212
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	214,067	212,053
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	10,956,813	3,423,961
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	11,761,211	(2,703,376)
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	119,266	162,910

HCRL Risk Corridor		
Assets	**2019**	**2018**
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	-	158,361
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 18,114,801	$ 15,081,396	$ 3,033,405	$ -	$ -	$ -
2015	17,262,163	17,262,163	-	-	-	-
2016	11,060,900	11,060,900	-	-	-	-
Total	$ 46,437,864	$ 43,404,459	$ 3,033,405	$ -	$ -	$ -

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

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the transitional HCRL reinsurance program as of December 31, 2019 and 2018:

	2019	2018
Assets		
Amounts recoverable for claims paid due to HCRL Reinsurance	$ -	$ -
Amounts recoverable for claims unpaid due to HCRL Reinsurance (Contra Liability)	-	-
Amounts receivable relating to uninsured plans for contributions for HCRL Reinsurance	-	-
Liabilities		
Liabilities for contributions payable due to HCRL Reinsurance – not reported as ceded premium	-	-
Ceded reinsurance premiums payable due to HCRL Reinsurance	-	-
Liabilities for amounts held under uninsured plans contributions for HCRL Reinsurance	-	-
Operations (Revenues & Expenses)		
Ceded reinsurance premiums due to HCRL Reinsurance	-	-
Reinsurance recoveries (income statement) due to HCRL Reinsurance payments or expected payments	581,309	14,415
HCRL Reinsurance contributions – not reported as ceded premiums	-	-

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal government of $43,404,459 in payments for the Company under the risk corridor premium stabilization program established under the HCRL, for the years 2014, 2015 and 2016. Humana's case has been stayed by the Court, pending resolution of similar cases filed by other insurers. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. As such, Humana will continue to seek payments owed to it. The Company has not recognized premiums, nor has it recorded a receivable for any amount due from the federal government for unpaid risk corridor payments as of December 31, 2019. The Company has fully recognized all liabilities due to the federal government that it has incurred under the risk corridor program, and has paid all amounts due to the federal government as required.

In addition to the provisions discussed above, beginning in 2014, HHS paid the Company a portion of the health care costs for low-income individual members for which the Company assumes no risk in accordance with the HCRL. These cost subsidy payments ceased effective October 2017. The Company accounted for these subsidies as a deposit in its statutory statements of admitted assets, liabilities and surplus and as an operating activity in its statements of cash flows. The Company did not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies. Receipt and payment activity was accumulated at the state level and recorded in its statutory statements of admitted assets, liabilities and surplus in health care and other receivables or accounts payable and accrued expenses depending on the state balance at the end of the reporting period.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	479,212		13,642,404		(13,163,192)		13,163,192		A.	-	
2. Premium adjustments (payables) (including high risk pool payments)		(3,423,961)		(3,265,885)		(158,076)		(4,586,120)	B.		(4,744,196)
3. Subtotal ACA Permanent Risk Adjustment Program	479,212	(3,423,961)	13,642,404	(3,265,885)	(13,163,192)	(158,076)	13,163,192	(4,586,120)		-	(4,744,196)
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-		581,309		(581,309)		581,309		C.	-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance-not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	-	-	581,309	-	(581,309)	-	581,309	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		-		-		-			-	

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk Sharing Provisions	479,212	(3,423,961)	14,223,713	(3,265,885)	(13,744,501)	(158,076)	13,744,501	(4,586,120)		-	(4,744,196)

Explanation for adjustments

A. Adjustments related to updates received from CMS associated with 2018 benefit year and the latest data from Wakely Consulting.

B. Small Group estimate changes for unfinalized years, based on latest data from Wakely Consulting.

C. Adjustments related to payments received from CMS associated with 2016 benefit year.

Net collections and payments under the 3Rs associated with prior coverage years were $(10,957,828) and $21,486,199 in 2019 and 2018, respectively. The Company collected all reinsurance recoverables relating to prior coverage years in 2018.

n. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 9. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2019, 2018, and 2017:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days After Billing
12/31/2019	$ 857,149,998	$ 857,149,998	$ -	$ -	$ -
9/30/2019	983,974,614	983,974,614	976,954,193	-	-
6/30/2019	1,557,140,947	1,557,140,947	1,538,340,203	4,788,022	-
3/31/2019	1,105,668,614	1,105,668,614	1,095,342,361	-	5,770,691
12/31/2018	871,791,853	871,791,853	861,944,025	4,597,680	2,304,301
9/30/2018	1,019,941,316	1,019,941,316	1,016,254,784	3,686,532	-
6/30/2018	1,351,608,731	1,351,608,731	1,346,148,031	5,460,700	-
3/31/2018	914,970,239	914,970,239	914,970,239	-	-
12/31/2017	792,665,292	792,665,292	748,733,774	42,233,855	1,697,663
9/30/2017	839,797,724	839,797,724	839,456,062	-	341,662
6/30/2017	803,680,635	803,680,635	802,965,453	607,609	107,573
3/31/2017	831,181,809	831,181,809	831,166,820	-	14,989

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $28,534,552 and $3,686,532 were nonadmitted at December 31, 2019 and 2018, respectively.

o. **Risk-Share Agreements:** The Company negotiates contractual agreements with group Medicare customers, some of which contain gain sharing provisions in the event the benefit ratio is less than an agreed-upon level. In these agreements, the Company and the customers generally share evenly in the gain. The Company recorded gain share payable of $40,715,660 and $8,292,453 as of December 31, 2019 and 2018, respectively, which is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

p. **Benefits Incurred and Loss Adjustment Expenses:** Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The Company recorded premium deficiency liabilities of $2,189,000 at December 31, 2018 but none were recorded at December 31, 2019. The liability at December 31, 2018 is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

q. **Reserves for Life Contracts and Deposit-Type Contracts:** The Company waives the deduction of deferred fractional premiums upon death of the insured and holds net level or modified premium reserves on mortality and interest bases that are consistent with statutory guidance. The Company does not return any portion of the final premium for periods beyond the date of death. Surrender values are not promised in excess of the legally computed reserves.

As of December 31, 2019 and 2018 the Company did not have any life insurance in force for which the gross premiums were less than the net premiums according to the standard valuation set by the OCI, as described in SSAP No. 51, *Life Contracts* (SSAP No.51). As discussed in Note 9, all non-health insurance business, including all associated reserves, was ceded to Humana Insurance Company of Kentucky (HICK) as of January 1, 2013.

r. **Administrative Service Only Contracts (ASO):** Administrative services fees cover the processing of claims, offering access to the Company's provider networks and clinical programs and responding to customer service inquiries from members of self-funded groups. Fees from providing administrative services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from Humana to cover catastrophic claims or to limit aggregate annual costs. The Company does not reflect payment of ASO claims in its statutory statements of revenue and expenses.

s. **Mortgage Loans:** Mortgage loans are current and carried at unpaid principal balances, net of discounts/premiums and valuation allowances. The Company has estimated the book/adjusted carrying value of its mortgage loans, to be $8,550,000 at December 31, 2019 and 2018. This estimate was established using a discounted cash flow method based on rating, maturity and future income when compared to the expected yield for mortgages having similar characteristics. The rating for mortgages in good standing is based on property type, location, market conditions, occupancy, debt service coverage, loan to value, caliber of tenancy, borrower and payment record. Problem mortgages are priced to reflect their monetary value to the Company, considering such things as the degree of default, whether or not the payments are still being made, interest rate, maturity and operating performance of the underlying collateral.

During 2019 and 2018, the maximum and minimum lending rates for mortgage loans were 6.65% at both year ends. At the issuance of a loan, the percentage of loan to value on any one loan does not exceed 100.

t. **Nonadmitted Assets:** Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, furniture and equipment, prepaid commissions

and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

u. Going Concern Considerations: Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). Based on this evaluation, Management has determined that there is no substantial doubt about the Company's ability to continue as a going concern.

v. Subsequent Events: The Company evaluated subsequent events through April 30, 2020, the date these financial statements were issued or available to be issued.

On January 1, 2020, the Company will be subject to the annual fee under Section 9010 of the HCRL as described in Note 2(b). The Consolidated Appropriations Act enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurance industry fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurance industry fee, but the fee has resumed for calendar year 2020. No segregation was recorded within special surplus for the annual health insurance industry fee related to the 2018 data year due to the moratorium. The further consolidated Appropriations Act 2020, enacted on December 20, 2019, permanently repealed the health insurance industry fee for calendar years 2021 and thereafter. In 2018, the Company was subject to an annual fee under section 9010 of the HCRL. This annual health insurance industry fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. The 2018 health insurance industry fee was paid September 30, 2018. The impact of the annual health insurance industry fee on the Company's operations as of December 31, 2019 and 2018 were as follows:

	2019	2018
HCRL fee assessment payable	$ 510,143,497	$ -
HCRL fee assessment paid	-	465,787,513
Premium written subject to HCRL 9010 assessment	25,663,900,250	-
Total Adjusted Capital Level before surplus adjustment	4,130,039,768	3,721,217,981
Total Adjusted Capital Level after surplus adjustment	3,619,896,271	3,721,217,981
Authorized Control Level after surplus adjustment	1,014,950,193	911,846,230

On March 16, 2020, the Company requested to pay a dividend to its parent Humana of $300,000,000 of which all was ordinary. The Company received approval to pay the dividend from the OCI on March 31, 2020. The Company paid the dividend on April 7, 2020.

The Company is not aware of any events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements which may have a material effect on its financial condition.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2019 and 2018 were as follows:

	2019			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 49,880,748	$ 146,367	$ (19,267)	$ 50,007,848
States, territories and possessions	82,100,971	1,337,974	(7,230)	83,431,715
Political subdivisions of states, territories and possessions	76,481,989	1,225,540	(8,034)	77,699,495
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,471,704,396	32,996,082	(1,148,248)	1,503,552,230
Industrial and miscellaneous	1,896,705,219	40,483,442	(1,693,862)	1,935,494,799
Total bonds	$ 3,576,873,323	$ 76,189,405	$ (2,876,641)	$ 3,650,186,087

	2018			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 45,220,981	$ 2,270	$ (1,350,214)	$ 43,873,037
States, territories and possessions	376,467,263	133,524	(4,760,328)	371,840,459
Political subdivisions of states, territories and possessions	18,807,835	-	(87,537)	18,720,298
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,339,785,888	1,212,255	(22,068,751)	1,318,929,392
Industrial and miscellaneous	1,766,934,171	463,605	(39,646,646)	1,727,751,130
Total bonds	$ 3,547,216,138	$ 1,811,654	$ (67,913,476)	$ 3,481,114,316

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The book/adjusted carrying value and estimated fair value of bonds and short-term investments at December 31, 2019, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 780,449,993	$ 780,522,350
Due after one year through five years	687,672,604	702,478,327
Due after five years through ten years	615,771,730	638,632,009
Due after ten years	232,815,785	239,242,077
Mortgage and asset-backed securities	1,890,103,119	1,919,251,233
	$ 4,206,813,231	$ 4,280,125,996

The detail of realized gains (losses) of bonds for the years ended December 31, 2019 and 2018 were as follows:

	2019	2018
Gross realized gains	$ 17,011,113	$ 12,051,356
Gross realized losses	(2,674,574)	(2,486,332)
Net realized (losses)	$ 14,336,539	$ 9,565,024

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2019 and 2018 were as follows:

	2019					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ 11,573,060	$ (19,267)	$ 11,573,060	$ (19,267)
States, territories and possessions	-	-	13,613,712	(7,230)	13,613,712	(7,230)
Political subdivisions of states, territories and possessions	-	-	11,278,345	(8,034)	11,278,345	(8,034)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	156,178,517	(712,278)	64,880,895	(435,970)	221,059,412	(1,148,248)
Industrial and misc.	85,536,366	(336,295)	326,158,813	(1,357,567)	411,695,179	(1,693,862)
Total invested assets	$ 241,714,883	$ (1,048,573)	$ 427,504,825	$ (1,828,068)	$ 669,219,708	$ (2,876,641)

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

	2018					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 3,467,242	$ (4,297)	$ 39,833,832	$ (1,345,917)	$ 43,301,074	$ (1,350,214)
States, territories and possessions	104,923,870	(1,126,095)	245,329,916	(3,634,233)	350,253,786	(4,760,328)
Political subdivisions of states, territories and possessions	10,508,908	(51,453)	8,211,390	(36,084)	18,720,298	(87,537)
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	553,821,700	(8,066,377)	536,624,678	(14,002,374)	1,090,446,378	(22,068,751)
Industrial and misc.	963,697,674	(16,963,682)	529,889,721	(22,682,964)	1,493,587,395	(39,646,646)
Total invested assets	$ 1,636,419,394	$ (26,211,904)	$ 1,359,889,537	$ (41,701,572)	$ 2,996,308,931	$ (67,913,476)

The unrealized loss from all securities was generated from 116 investment positions at December 31, 2019. All issuers of securities the Company owns that were trading at an unrealized loss at December 31, 2019 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2019, the Company did not intend to sell the securities with an unrealized loss position, and it is not likely that the Company will be required to sell these securities before recovery of their amortized cost basis. As a result, the Company believes that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2019.

Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Reinsurance

The Company reinsures portions of its business through various reinsurance treaties. These treaties protect the Company from sustaining losses above predetermined levels and are included as a reduction of earned premiums in the accompanying statements of revenue and expenses. Although the reinsurer in each case is primarily liable on the insurance ceded, the Company remains liable to the insured whether or not the reinsurer meets its contractual obligations.

Effective August 3, 2018, retroactive to January 1, 2018, the company entered into a 100% Indemnity Coinsurance Assumed agreement with Kanawha Insurance Company (KIC), a related party at the time. Under the terms of the contract, the Company assumed the group life and disability policies of KIC. Effective August 9, 2018, pursuant to the Stock Purchase Agreement signed on November 6, 2017 between Humana and Continental General Insurance Company, KIC was sold and no longer affiliated with the Company. Effective January 1, 2019, the Company novated an inuring third party reinsurance agreement originally between KIC and Hartford Life and Accident Insurance Company. As a result, the Company now reports the related policies as 100% assumed and ceded. At the end of 2018 and throughout 2019, there were no active premium paying members related to the block of business subject to these agreements, as all remaining policies were in run-out. There were $15,014,679 reserves assumed and ceded and no premiums assumed or ceded as of and for the year ended December 31, 2019, respectively. There were $492,591 reserves assumed and $4,619,770 premiums assumed as of and for the year ended December 31, 2018, respectively.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

Effective June 29, 2018 and August 3, 2018, retroactive to January 1, 2018, the Company entered into 100% Indemnity Coinsurance and Assumption reinsurance agreements with ManhattanLife Assurance Company of America and Manhattan Life Insurance Company, respectively, both are unrelated entities. Under the terms of the contracts, the Company ceded its individual life, annuity and supplemental health products such as cancer, critical illness, hospital indemnity and accident policies. Initial policy and claim reserves transferred were $18,893,620. For the years ended December 31, 2019 and 2018, there were $6,362,749 and $6,226,517 premiums ceded, respectively, related to this agreement. Total reserves ceded were $1,726,930 and $11,993,284 for the years ended December 31, 2019 and 2018, respectively. The Company did not commute any ceded reinsurance or write-off any reinsurance balances during 2019 or 2018.

The Company has reinsurance contracts with various insurers and affiliates as noted within Note 9. For the years ended December 31, 2019 and 2018 there were $68,276,205 and $99,831,984 premiums ceded, respectively, related to these contracts.

The Company has not entered into any reinsurance agreements in which the reinsurer may unilaterally cancel any reinsurance for reasons other than nonpayment of premiums or other amounts due. The Company does not have any reinsurance agreements in effect in which the amount of losses paid or accrued through December 31, 2019 or 2018 would result in a payment to the reinsurer of amounts which, in the aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premiums collected under the reinsured policies.

5. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2019 and 2018 were as follows:

	2019		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 111,944,692	$ 214,010	$ 112,158,702
Statutory valuation allowance adjustment	-	(214,010)	(214,010)
Adjusted gross deferred tax assets	111,944,692	-	111,944,692
Deferred tax assets nonadmitted	(13,267,892)	-	(13,267,892)
Subtotal net admitted deferred tax assets	98,676,800	-	98,676,800
Gross deferred tax liabilities	(5,412,854)	-	(5,412,854)
Net admitted deferred tax asset/(liability)	$ 93,263,946	$ -	$ 93,263,946

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

	2018		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 88,121,826	$ 1,743,476	$ 89,865,302
Statutory valuation allowance adjustment	-	(1,743,476)	(1,743,476)
Adjusted gross deferred tax assets	88,121,826	-	88,121,826
Deferred tax assets nonadmitted	(10,324,167)	-	(10,324,167)
Subtotal net admitted deferred tax assets	77,797,659	-	77,797,659
Gross deferred tax liabilities	(3,164,722)	-	(3,164,722)
Net admitted deferred tax asset/(liability)	$ 74,632,937	$ -	$ 74,632,937

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2019 and 2018 were as follows:

	December 31, 2019		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 90,610,040	$ -	$ 90,610,040
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	2,653,906	-	2,653,906
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	2,653,906
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	598,510,343
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	5,412,854	-	5,412,854
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 98,676,800	$ -	$ 98,676,800

	December 31, 2018		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 72,580,190	$ -	$ 72,580,190
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	2,052,747	-	2,052,747
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	2,052,747
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	538,775,017
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	3,164,722	-	3,164,722
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 77,797,659	$ -	$ 77,797,659

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2019	2018
Ratio percentage used to determine recovery period and threshold limitation amount	393%	394%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 3,990,068,953	$ 3,591,833,447

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2019 and 2018 consisted of the following:

	2019	2018
Current year income tax provision	$ 283,808,079	$ 297,497,046
Revisions in prior years' estimated taxes	(3,785,230)	(43,308,258)
Federal income tax expense excluding the tax on realized capital gains and before change in net deferred income taxes	280,022,849	254,188,788
Tax on realized capital gains	3,010,673	1,989,160
Change in net deferred income taxes	(21,574,734)	50,745,131
Total statutory income taxes	$ 261,458,788	$ 306,923,079

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2019 and 2018 were as follows:

	2019	2018	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 32,199,087	$ 27,379,248	$ 4,819,839
Advance premiums	4,122,960	4,603,496	(480,536)
Policyholder reserves	186,900	169,581	17,319
Investments	-	-	-
Deferred acquisition costs	24,683,173	18,214,629	6,468,544
Policyholder dividends accrual	-	-	-
Fixed assets	-	-	-
Compensation and benefit accruals	21,648,132	18,882,304	2,765,828
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	2,092,226	108,996	1,983,230
Bad debts	2,582,190	1,778,087	804,103
Accrued litigation	1,562,913	43,470	1,519,443
CMS Rx reserves	20,303,218	15,255,850	5,047,368
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	732,177	362,960	369,217
Accrued lease	502,952	824,602	(321,650)
Section 197 intangibles	300,963	335,359	(34,396)
Reinsurance fee	-	-	-
Provider contracts	1,027,801	163,244	864,557
Gross ordinary DTAs	111,944,692	88,121,826	23,822,866
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(13,267,892)	(10,324,167)	(2,943,725)
Admitted ordinary DTAs	98,676,800	77,797,659	20,879,141
Capital			
Investments	214,010	1,743,476	(1,529,466)
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	214,010	1,743,476	(1,529,466)
Statutory valuation allowance adjustment	(214,010)	(1,743,476)	1,529,466
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 98,676,800	$ 77,797,659	$ 20,879,141

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

	2019	2018	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	(3,042,623)	(56,361)	(2,986,262)
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(78,410)	(77,679)	(731)
CMS Rx Reserve	-	-	-
Reserve Transition Adjustment	(2,291,821)	(3,030,682)	738,861
Ordinary DTLs	(5,412,854)	(3,164,722)	(2,248,132)
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(5,412,854)	(3,164,722)	(2,248,132)
Net deferred tax assets/(liabilities)	$ 93,263,946	$ 74,632,937	$ 18,631,009

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the ordinary DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no ordinary DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from. A statutory valuation allowance has been set up for deferred taxes on future capital loss items, due to uncertainty regarding the timing of their reversal.

The change in nonadmitted deferred tax assets from December 31, 2018 to 2019 was an increase of $2,943,725. The change in nonadmitted deferred tax assets from December 31, 2017 to 2018 was a decrease of $6,787,401.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the dividends received deduction, change to nonadmitted assets & deferred tax true-ups and tax-exempt interest in 2019.

The Company had no net operating loss carryforwards at December 31, 2019 or 2018.

The following table demonstrates the income tax expense for 2018 and 2019 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2018	$ 275,488,927	$ 1,989,160	$ 277,478,087
2019	283,808,079	3,010,673	286,818,752
	$ 559,297,006	$ 4,999,833	$ 564,296,839

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2019 or 2018.

As of December 31, 2019, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana's consolidated income tax returns for 2017 and prior years. Humana's 2018 tax return is in the post-filing review period under the Compliance Assurance Process (CAP). Humana's 2019 tax return is under advance review by the IRS under CAP. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2019 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2019
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	AMERICAN ELDERCARE, INC.	65-0380198
6	ARCADIAN HEALTH PLAN, INC.	20-1001348
7	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
8	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
9	CARENETWORK, INC.	39-1514846
10	CAREPLUS HEALTH PLANS, INC.	59-2598550
11	CARITEN HEALTH PLAN INC.	62-1579044
12	CHA HMO, INC.	61-1279717
13	CHA SERVICE COMPANY, INC.	61-1279716
14	COMPBENEFITS COMPANY	59-2531815
15	COMPBENEFITS CORPORATION	04-3185995

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

16	COMPBENEFITS DENTAL, INC.	36-3686002
17	COMPBENEFITS DIRECT, INC.	58-2228851
18	COMPBENEFITS INSURANCE COMPANY	74-2552026
19	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
20	CONTINUCARE CORPORATION	59-2716023
21	CONTINUCARE MEDICAL MANAGEMENT, INC.	65-0791417
22	CONTINUCARE MSO, INC.	65-0780986
23	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
24	DENTICARE, INC.	76-0039628
25	EDGE HEALTH MSO, INC.	84-2214810
26	EDGE HEALTH, P.C.	84-2752906
27	EMPHESYS INSURANCE COMPANY	31-0935772
28	EMPHESYS, INC.	61-1237697
29	FAMILY PHYSICIANS OF WINTER PARK, INC.	59-3164234
30	FPG ACQUISITION CORP.	81-3802918
31	FPG ACQUISITION HOLDINGS CORP.	81-3819187
32	FPG HOLDING COMPANY, LLC	32-0505460
33	HARRIS, ROTHENBERG INTERNATIONAL, INC.	27-1649291
34	HEALTH VALUE MANAGEMENT, INC.	61-1223418
35	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
36	HUMANA AT HOME (DALLAS), INC.	75-2739333
37	HUMANA AT HOME (HOUSTON), INC.	76-0537878
38	HUMANA AT HOME (SAN ANTONIO), INC.	01-0766084
39	HUMANA AT HOME (TLC), INC.	75-2600512
40	HUMANA AT HOME 1, INC.	65-0274594
41	HUMANA AT HOME, INC.	13-4036798
42	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
43	HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.	84-3226630
44	HUMANA BENEFIT PLAN OF TEXAS, INC. (f/k/a HUMANA BEHAVIORAL HEALTH, INC.)	75-2043865
45	HUMANA DENTAL COMPANY	59-1843760
46	HUMANA DIGITAL HEALTH AND ANALYTICS PLATFORM SERVICES, INC. (f/k/a TRANSCEND INSIGHTS, INC.)	80-0072760
47	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
48	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
49	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
50	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
51	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
52	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
53	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
54	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
55	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632
56	HUMANA HEALTH PLAN, INC.	61-1013183
57	HUMANA HEALTHCARE RESEARCH, INC.	42-1575099
58	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
59	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
60	HUMANA INSURANCE COMPANY	39-1263473
61	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
62	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

63	HUMANA MARKETPOINT, INC.	61-1343508
64	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
65	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
66	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
67	HUMANA MEDICAL PLAN, INC.	61-1103898
68	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
69	HUMANA PHARMACY, INC.	61-1316926
70	HUMANA REAL ESTATE COMPANY (f/k/a PRESERVATION ON MAIN, INC.)	20-1724127
71	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
72	HUMANA VETERANS HEALTHCARE SERVICES, INC.	20-8418853
73	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
74	HUMANADENTAL INSURANCE COMPANY	39-0714280
75	HUMANADENTAL, INC.	61-1364005
76	HUMCO, INC.	61-1239538
77	HUM-e-FL, INC.	61-1383567
78	MANAGED CARE INDEMNITY, INC.	61-1232669
79	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
80	METCARE OF FLORIDA, INC.	65-0879131
81	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
82	PARTNERS IN INTEGRATED CARE, INC.	47-2905609
83	PARTNERS IN PRIMARY CARE (GA), P.C.	83-2624178
84	PARTNERS IN PRIMARY CARE (KS), P.C.	82-2000699
85	PARTNERS IN PRIMARY CARE (NC), P.C.	82-1926920
86	PARTNERS IN PRIMARY CARE, P.A.	47-1161014
87	PHP COMPANIES, INC.	62-1552091
88	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
89	PRIMARY CARE HOLDINGS, INC.	46-1225873
90	ROHC, LLC	75-2844854
91	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
92	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
93	TEXAS DENTAL PLANS, INC.	74-2352809
94	THE DENTAL CONCERN, INC.	52-1157181
95	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
96	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
97	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105
98	TRANSCEND POPULATION HEALTH MANAGEMENT, LLC	46-5329373

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

6. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2019 and 2018 are summarized as follows:

	2019	2018
Balance at January 1,	$ 2,202,442,434	$ 2,033,585,308
Benefits incurred and loss adjustment expenses related to		
Current year	22,979,526,929	21,281,912,024
Prior year	(44,315,754)	(193,737,626)
	22,935,211,175	21,088,174,398
Benefits and loss adjustment expenses paid related to		
Current year	20,553,416,121	19,411,499,315
Prior year	2,143,883,789	1,507,817,957
	22,697,299,910	20,919,317,272
Balance at December 31,	$ 2,440,353,699	$ 2,202,442,434

Benefits and loss adjustment expenses payable at December 31, 2018 and 2017 ultimately settled during 2019 and 2018 for $44,315,754 and $193,737,626 less, respectively, than the amounts originally estimated as a result of favorable developments of unpaid claims and claim adjustment expenses principally on Medicare operations. These favorable developments were generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. The Company did not record any adjustments to premiums related to prior period claims development.

7. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the OCI statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the OCI is the lesser of 10% of total surplus or net gain from operations from the prior year. All ordinary dividends are limited to available and accumulated surplus funds. Based on these restrictions, the Company could have paid a maximum dividend or return of capital to shareholders of approximately $372,000,000 in 2019 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. Extraordinary amounts have been approved by the OCI.

		Dividend or Return of Capital Amount		
		Ordinary	Extraordinary	Date Paid
Dividend		$ -	$ 575,000,000	April 30, 2019
Dividend		-	100,000,000	December 30, 2019
	Total paid in 2019	$ -	$ 675,000,000	
Dividend		$ -	$ 975,000,000	April 20, 2018
Dividend		-	350,000,000	December 19, 2018
	Total paid in 2018	$ -	$ 1,325,000,000	

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

8. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Wisconsin has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $1,014,950,193 or the Company, under the discretion of the Commissioner of the OCI, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Wisconsin which require a minimum capital and surplus level of $3,493,860,899 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $4,129,404,995 and $3,720,672,880 as of December 31, 2019 and 2018, respectively.

9. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $3,158,543 and $5,036,781 for the years ended December 31, 2019 and 2018, respectively.

Employees of the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2019 and 2018 total allocated expenses associated with these plans were $25,328,381 and $20,266,799, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2019 and 2018 were $(497,630,601) and $(71,865,173), respectively which are recorded as a charge to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses. These amounts are net of fees received for services provided to wholly owned subsidiaries of Humana whereby the Company provides claims processing, billing and enrollment and other services as required by the subsidiaries. These amounts are allocated to the affiliates using a method that approximates an amount as if the expense had been incurred solely by the affiliates. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 5, which were $298,325,325 and $292,138,030 for the years ended December 31, 2019 and 2018, respectively. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $192,687,773 and $64,578,016 due from Humana at December 31, 2019 and 2018, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

In the ordinary course of business, the Company also directly contracts with related parties to provide services that are routine in nature to its members. The administrative services, access fees, and cost of care services provided are determined within each individual agreement. These amounts are included in benefits incurred and loss adjustment as well as selling, general and administrative expenses in the statutory statements of revenue and expenses.

The following table identifies the amount for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2019 and 2018, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliate and Other Related Parties* (SSAP No. 25):

	2019	2018
SeniorBridge and Humana At Home, Inc.	$ 164,357,710	$ 221,535,107
Total	$ 164,357,710	$ 221,535,107

SeniorBridge and Humana at Home, Inc. provide in-home care as well as telephonic care management to eligible Humana members.

In addition to the related parties above, the Company also has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(n) for further consideration of related pharmacy rebates. The Company had $16,437,891,312 and $15,852,736,551 of administrative service and prescription costs in 2019 and 2018, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives, and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(l).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $3,745,299,190 and $3,641,158,810 of prescription costs in 2019 and 2018, respectively, with Humana Pharmacy, Inc.

The Company has an intercompany reinsurance agreement with its subsidiary, HICK. Under the terms of the contract, the Company cedes business including all of its group life, specified disease, disability income, and accident insurance business. For the years ended December 31, 2019 and 2018 there were $50,534,711 and $77,747,242 premiums ceded, respectively, related to this agreement.

The Company entered into a mortgage agreement with Humana on property held by the Company effective February 1, 1999, for $8,550,000 plus accrued interest. The note bears interest only at the rate of 6.65%. The principal and accrued interest amounts were originally due and payable to the Company on January 31, 2009, however, the due date was extended to January 31, 2021. The Company carries this note at book value of $8,550,000.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

The Company received no capital contributions in the years ended December 31, 2019 or 2018.

Humana forgave $19,984,786 of the Company's tax liability due to Humana as part of the Company's tax sharing agreement during 2019. The portion of the tax balance being forgiven is associated with an issue that is currently subject to IRS Appeals. The forgiveness was accounted for as contributed surplus per SSAP No. 72 *Surplus and Quasi-Reorganizations* (SSAP No. 72).

10. Employee Benefit Plans

The Company's employees are eligible to participate in the Humana Retirement Savings Plan (the Plan), a defined contribution plan, sponsored by Humana. The Plan maintains two accounts, the Savings Account and the Retirement Account. Humana's total contributions paid to the Plan were $219,268,247 and $194,704,927 for the years ended December 31, 2019 and 2018, respectively. Of these contributions, the Company contributed $110,527,415 and $93,255,484 during 2019 and 2018, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses. As of December 31, 2019 and 2018, the fair market value of the Humana Retirement Savings Plan's assets were $5,344,599,370 and $4,284,204,823, respectively.

11. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to six years. Operating lease rental payments charged to expenses for the years ended December 31, 2019 and 2018 was $40,170,122 and $19,852,732, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

In 2019 and 2017, the Company terminated lease agreements early resulting in the recognition of a liability included within accounts payable and accrued expenses within the accompanying statements of admitted assets, liabilities and surplus. The following table includes the leases terminated and the related liability remaining at December 31, 2019 and 2018:

	2019	2018
Tempe Commerce Center	$ 359,844	$ -
Memphis TN	-	8,032
Total liability	$ 359,844	$ 8,032

Future minimum rental payments required under operating leases as of December 31, 2019, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,	
2020	$ 20,518,812
2021	19,158,398
2022	14,204,849
2023	7,254,354
2024	2,784,427
Thereafter	12,442,987
Total minimum lease payments	$ 76,363,827

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

12. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $23,670,125,040 and $22,195,966,618 for the years ended December 31, 2019 and 2018, respectively. The loss of the Contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2020, and all product offerings filed with CMS for 2020 have been approved.

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

CMS is phasing-in the process of calculating risk scores using diagnoses data from the RAPS to diagnoses data from the EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score was calculated from claims data submitted through EDS. CMS will increase that percentage to 50% in 2020 and has proposed to increase that percentage to 75% in 2021. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on the Company's results of statutory statements of revenue and expenses, changes in surplus, or cash flows.

CMS and the Office of the Inspector General of Health and Human Services (HHS-OIG) are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation (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 RADV Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of the government's traditional fee-for-service Medicare program, or Medicare FFS. The Company refers to the process of accounting for errors in FFS claims as the FFS Adjuster. This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for payment years 2015, 2014 and 2012.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2014. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana believes that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and has provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on the

Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus, or cash flows.

Humana believes that, CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS' final rule release regarding MA and Part D prescription drug benefit program regulations for Contract Year 2015 (referred to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each MA risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

The Company 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 the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

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

b. COVID-19: The spread of the novel coronavirus, or COVID-19, and the emergence of stay-at-home and physical distancing orders and other restrictions on movement and economic activity intended to reduce the spread of COVID-19 in the second half of March 2020 in the United States of America, has impacted the Company's business. A number of significant variables and uncertainties precludes any estimation as to the ultimate impact from COVID-19 including, among others, the severity and duration of the pandemic, continued actions taken to mitigate the spread of COVID-19 and in turn, relax those restrictions, the timing and degree in resumption of demand for deferred health care services, the ability of our commercial members to pay their premium, the nature and level of diagnostic testing, the cost and timing of new therapeutic treatments and vaccines.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

c. Legal Proceedings: During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus, and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus, and cash flows, and may also affect the Company's reputation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided Humana's legal counsel with an information request concerning Humana's Medicare Part C risk adjustment practices. The request relates to Humana's oversight and submission of risk adjustment data generated by providers in its MA network, as well as to its business and compliance practices related to risk adjustment data generated by its providers and by Humana, including medical record reviews conducted as part of its data and payment accuracy compliance efforts, the use of health and well-being assessments, and fraud detection efforts. Humana believes that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of MA plans, providers and vendors. Humana continues to cooperate with and voluntarily respond to the information requests from the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned United States of America ex rel. Steven Scott v. Humana, Inc., in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by Humana in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by it under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. Humana takes seriously its obligations to comply with applicable CMS requirements and actuarial standards of practice, and continues to vigorously defend against these allegations since the transfer to the Western District of Kentucky. Humana has engaged in active discovery with the relator who has pursued the matter on behalf of the United States following its unsealing, and expects that discovery process to conclude in the near future and for the Court to consider its motion for summary judgment.

d. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

e. Securities & Credit Markets Risks: Volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

f. Penn Treaty: Penn Treaty is a financially distressed unaffiliated long-term care insurance company. On March 1, 2017, the Pennsylvania Commonwealth Court approved the liquidation of Penn Treaty. Under state guaranty assessment laws, including those related to state

cooperative failures in the industry, the Company may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as the Company. This court ruling triggered a guaranty fund assessment for the Company in the first quarter of 2017. Based on current information, the assessment is estimated at approximately $32,864,295 with a remaining unpaid balance as of December 31, 2019 of $9,006,178 included in accounts payable and accrued expenses in the accompanying statements of admitted assets, liabilities and surplus. The Company has also recognized an asset for premium tax credits associated with the assessment at December 31, 2019 and 2018 of $12,463,679 and $14,213,948, respectively, which are expected to be realized over the next 20 years. While the ultimate payment timing and associated recovery is currently unknown, the Company anticipates that the majority of the assessments will be paid within the next 5 years.

The below table reconciles the asset for premium tax credits associated with the assessment at December 31, 2018 to those reported at December 31, 2019.

a.) Assets recognized from paid and accrued premium tax offsets and policy surcharges prior year-end	$	14,213,948
b.) Decreases current year: Misc. Adjustments		1,750,269
c.) Increases current year:		-
d.) Assets recognized from paid and accrued premium tax offsets and policy surcharges current year-end	$	12,463,679

Discount rate applied: 3.50%

The Undiscounted and Discounted Amount of the Guaranty Fund assessments and Related Assets by Insolvency:

Name of the Insolvency	Guaranty Fund Assessment		Related Assets	
	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty	$ 46,667,299	$ 32,864,295	$ 28,063,537	$ 12,463,679

Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency:

	Payables			Recoverables		
Name of the Insolvency	Number of Jurisdictions	Range of Years	Weighted Average Number of Years	Number of Jurisdictions	Range of Years	Weighted Average Number of Years
Penn Treaty	50 states	1 to 70 years	11.96 years	39 states	1 to 20 years	8.1 years

13. Uninsured Plans

Information for the year ended December 31, 2019 regarding the profitability of ASO plans and the uninsured portion of partially insured plans for which the Company provides administrative services were as follows:

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2019 and 2018

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	$ 8,992,793	$ (21,934,669)	$ (12,941,877)
Total net other income or expenses (including interest paid to or received from plans)	(8,544)	(51,302)	(59,846)
Net gain (loss) from operations	$ 8,984,249	$ (21,985,971)	$ (13,001,723)
Total claim payment volume	211,319,360	418,635,207	629,954,567

As of December 31, 2019, the Company has recorded a receivable from CMS of $482,892,958 related to the cost share and reinsurance components of administered Medicare products and a receivable from ASO customers of $12,042,800. The Company has recorded receivables from the following payors whose account balance are greater than 10% of the Company's accounts receivable from uninsured accident and health plans or $10,000:

	2019
Advocate Health Care APP	$ 2,653,200
Excela Health	1,125,444
Maricopa Community College	1,116,047
Baptist Health Floyd	921,229

	2018
Advocate Health Care APP	$ 2,273,917
Maricopa Community College	967,906
DST Systems Inc.	919,670

Supplemental Investment Information

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

Of the **Humana Insurance Company**
Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436
NAIC Group Code 0119 NAIC Company Code 73288 Employer's ID Number 39-1263473

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 3 of the statement of admitted assets, liabilities and surplus. $7,990,533,957.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	The Goldman Sachs Group, Inc.	BONDS	$ 55,469,072	0.69%
2.02	Pfizer Inc.	BONDS	51,865,485	0.65%
2.03	Toyota Motor Credit Corporation	BONDS	50,672,042	0.63%
2.04	Bank of America Corporation	BONDS	50,168,604	0.63%
2.05	Cd 2017-Cd3	BONDS	46,791,640	0.59%
2.06	Bristol-Myers Squibb Company	BONDS	45,774,713	0.57%
2.07	Apple Inc.	BONDS	45,406,896	0.57%
2.08	Wells Fargo & Company	BONDS	43,378,866	0.54%
2.09	BMW US Capital, LLC	BONDS	43,329,288	0.54%
2.10	The Walt Disney Company	BONDS	42,514,035	0.53%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 4,080,097,234	51.06%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	673,748,121	8.43%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	183,353,137	2.29%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	6,759,488	0.08%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	294,400	0.00%	3.12	P/RP-6	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?		Yes [ ]	No [X]
4.02	Total admitted assets held in foreign investments.	$	343,695,145	4.30%
4.03	Foreign-currency-denominated investments.		-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency		-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	343,695,145	4.30%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

				1	2
	Countries rated NAIC - 1:				
6.01	Country:	Cayman Islands	$	233,279,432	2.92%
6.02	Country:	United Kingdom		37,682,923	0.47%
	Countries rated NAIC - 2				
6.03	Country:		$	-	0.00%
6.04	Country:			-	0.00%
	Countries rated NAIC - 3 or below				
6.05	Country:		$	-	0.00%
6.06	Country:			-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1	2	3	4
	Issuer	**NAIC Rating**		
10.01	Diageo Capital plc	1FE, 2FE	$ 22,552,890	0.28%
10.02	Park Avenue Institutional Advisers CLO Ltd 2017-1	1FE	18,850,000	0.24%
10.03	RR 3 LTD	1FE	16,625,000	0.21%
10.04	CBAM 2017-1, Ltd.	1FE	14,993,788	0.19%
10.05	Carlyle Global Market Strategies CLO 2014-3-R Ltd	1FE	14,342,494	0.18%
10.06	Neuberger Berman Loan Advisers Clo 26, Ltd.	1FE	13,841,822	0.17%
10.07	Tiaa Clo III Ltd	1FE	12,880,000	0.16%
10.08	Palmer Square CLO 2018-2 Ltd	1FE	12,848,784	0.16%
10.09	Carlyle US CLO 2017-4 Ltd	1FE	12,500,000	0.16%
10.10	AerCap Ireland Capital Designated Activity Company	2FE	11,969,050	0.15%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes	[X]	No	[ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.					
11.02	Total admitted assets held in Canadian Investments	$	-			0.00%
11.03	Canadian-currency-denominated investments		-			0.00%
11.04	Canadian-denominated insurance liabilities		-			0.00%
11.05	Unhedged Canadian currency exposure		-			0.00%

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes	[X]	No	[ ]	
	If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.					
	1		**2**			**3**
12.02	Aggregate statement value of investments with contractual sales restrictions	$	-			0.00%
	Largest 3 investments with contractual sales restrictions					
12.03			-			0.00%
12.04			-			0.00%
12.05			-			0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]
	If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.	

	1 Name of Issuer	2	3
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]
	If response to 14.01 above is yes, responses are not required for the remainder of interrogatory 14.	

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02	-	$ -	0.00%
16.03	-	-	0.00%
16.04	-	-	0.00%
16.05	-	-	0.00%
16.06	-	-	0.00%
16.07	-	-	0.00%
16.08	-	-	0.00%
16.09	-	-	0.00%
16.10	-	-	0.00%
16.11	-	-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02	-	$ -	0.00%
18.03	-	-	0.00%
18.04	-	-	0.00%
18.05	-	-	0.00%
18.06	-	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:		**2**	**3**
		$	-	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description **1**		**2**	**3**
19.03	-	$	-	0.00%
19.04	-		-	0.00%
19.05	-		-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2019

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Insurance Company
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2019

		Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
		1	2	1	2
		Amount	Percentage	Amount	Percentage
1. Long-Term Bonds					
1.01	U.S. governments	$ 49,880,748	0.85%	$ 49,880,748	0.85%
1.02	All other governments	-	0.00%	-	0.00%
1.03	U.S. states, territories and possessions, etc. guaranteed	82,100,971	1.40%	82,100,971	1.40%
1.04	U.S. political subdivisions of states, territories, and possessions, guaranteed	76,481,989	1.31%	76,481,989	1.31%
1.05	U.S. special revenue and special assessment obligations, etc. non-guaranteed	1,471,704,396	25.18%	1,471,704,396	25.18%
1.06	Industrial and miscellaneous	1,896,705,219	32.45%	1,896,705,219	32.45%
1.07	Hybrid securities	-	0.00%	-	0.00%
1.08	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
1.09	SVO identified funds	-	0.00%	-	0.00%
1.10	Unaffiliated Bank loans	-	0.00%	-	0.00%
1.11	Total long-term bonds	3,576,873,323	61.19%	3,576,873,323	61.20%
2. Preferred stocks					
2.01	Industrial and miscellaneous (Unaffiliated)	-	0.00%	-	0.00%
2.02	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
2.03	Total preferred stocks	-	0.00%	-	0.00%
3. Common stocks					
3.01	Industrial and miscellaneous Publicly traded (Unaffiliated)	-	0.00%	-	0.00%
3.02	Industrial and miscellaneous Other (Unaffiliated)	-	0.00%	-	0.00%
3.03	Parent, subsidiaries and affiliates Publicly traded	-	0.00%	-	0.00%
3.04	Parent, subsidiaries and affiliates Other	675,991,500	11.57%	675,991,500	11.57%
3.05	Mutual funds	-	0.00%	-	0.00%
3.06	Unit investment trusts	-	0.00%	-	0.00%
3.07	Closed-end funds	-	0.00%	-	0.00%
3.08	Total common stocks	675,991,500	11.57%	-	0.00%
4. Mortgage loans					
4.01	Farm mortgages	-	0.00%	-	0.00%
4.02	Residential mortgages	-	0.00%	-	0.00%
4.03	Commercial mortgages	8,550,000	0.15%	8,550,000	0.15%
4.04	Mezzanine real estate loans	-	0.00%	-	0.00%
4.05	Total mortgage loans	8,550,000	0.15%	8,550,000	0.15%
5. Real estate					
5.01	Properties occupied by company	12,321,647	0.21%	12,321,647	0.21%
5.02	Properties held for production of income	-	0.00%	-	0.00%
5.03	Properties held for sale	-	0.00%	-	0.00%
5.04	Total real estate	12,321,647	0.21%	12,321,647	0.21%
6. Cash, cash equivalents and short-term investments					
6.01	Cash	58,058,892	0.99%	58,058,892	0.99%
6.02	Cash equivalents	883,095,733	15.11%	883,095,733	15.11%
6.03	Short-term investments	629,939,908	10.78%	629,939,909	10.78%
6.04	Total cash, cash equivalents and short-term investments	1,571,094,533	26.88%	1,571,094,534	26.88%
7. Contract loans		-	0.00%	-	0.00%
8. Derivatives		-	0.00%	-	0.00%
9. Other invested assets		-	0.00%	-	0.00%
10. Receivables for securities		10,000	0.00%	10,000	0.00%
11. Securities Lending		-	0.00%	-	0.00%
12. Other invested assets		-	0.00%	-	0.00%
13.	Total invested assets	$ 5,844,841,003	100.00%	$ 5,844,841,004	100.00%

Humana Insurance Company

(a wholly owned subsidiary of CareNetwork Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2018 and 2017

Humana Insurance Company
Index
Statutory Basis of Accounting
December 31, 2018 and 2017

Page

Report of Independent Auditors 1

Financial Statements

Statements of Admitted Assets, Liabilities and Surplus 3

Statements of Revenue and Expenses 4

Statements of Changes in Surplus 5

Statements of Cash Flows 6

Notes to Financial Statements 7

Supplemental Investment Information

Investment Risk Interrogatories 48

Summary Investment Schedule 57

Report of Independent Auditors

To the Board of Directors of Humana Insurance Company

We have audited the accompanying statutory financial statements of Humana Insurance Company, which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2018 and 2017, and the related statutory statements of revenue and expenses and changes in surplus, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

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Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2018 and 2017, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin described in Note 2

Other Matter

Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements taken as a whole. The supplemental investment risk interrogatories and summary investment schedule (collectively, the "supplemental schedules") of the Company, as of December 31, 2018 and for the year then ended, are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the statutory-basis financial statements. The supplemental schedules are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The supplemental schedules have been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental schedules are fairly stated, in all material respects, in relation to the statutory-basis financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 29, 2019

Humana Insurance Company
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2018 and 2017

	2018	2017
Admitted Assets		
Cash and invested assets		
Bonds	$ 3,547,216,138	$ 3,172,559,234
Investment in subsidiaries	804,849,178	969,884,560
Mortgage notes receivable from Humana Inc.	8,550,000	8,550,000
Real estate occupied by the Company	13,576,713	14,972,075
Short-term investments	217,858,209	237,524,826
Total invested assets	4,592,050,238	4,403,490,695
Cash and cash equivalents	701,459,562	2,468,695,106
Total cash and invested assets	5,293,509,800	6,872,185,801
Premiums receivable	604,232,186	427,928,269
Investment income due and accrued	30,920,611	28,033,434
Amounts receivable relating to uninsured plans	151,386,173	84,090,326
Reinsurance receivable	23,210,968	21,630,214
Health care and other receivables	934,936,898	841,158,036
Current federal income tax recoverable	1,767,208	-
Net deferred tax assets	74,632,937	118,590,667
Electronic data processing equipment and software, less accumulated depreciation of $38,975,797 and $50,288,831 in 2018 and 2017, respectively	54,206,496	47,451,972
Receivable from Humana Inc.	64,578,016	275,574,930
Total admitted assets	$ 7,233,381,293	$ 8,716,643,649
Liabilities		
Benefits and loss adjustment expenses payable	$ 2,202,442,434	$ 2,033,585,308
Aggregate health policy reserves	298,437,261	376,703,468
Aggregate health claim reserves	2,533,000	2,398,000
Advance premiums	112,415,528	121,569,194
Accounts payable and accrued expenses	883,501,355	1,891,478,139
Funds held under reinsurance treaties	13,378,835	30,643,341
Current federal income tax payable	-	75,752,859
Total liabilities	3,512,708,413	4,532,130,309
Surplus		
Common stock, $8 par value; 15,000,000 shares authorized; 1,104,167 shares issued and outstanding	8,833,336	8,833,336
Gain on Reinsurance	1,106,711	-
Special surplus - projected HCRL fee assessment	-	474,068,972
Paid-in surplus	2,085,107,576	2,086,790,088
Unassigned surplus	1,625,625,257	1,614,820,944
Total surplus	3,720,672,880	4,184,513,340
Total liabilities and surplus	$ 7,233,381,293	$ 8,716,643,649

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2018 and 2017

	2018	2017
Earned premiums	$ 24,820,038,571	$ 22,921,174,154
Expenses		
Benefits incurred and loss adjustment expenses	21,088,174,398	19,548,411,486
Selling, general and administrative expenses	2,717,236,520	2,252,762,166
Changes in aggregate health policy reserves	994,315	(36,075,442)
Total expenses	23,806,405,233	21,765,098,210
Net underwriting gain	1,013,633,338	1,156,075,944
Net investment income	375,241,539	172,866,673
Net realized capital gains on investments (net of capital gains tax of $1,989,160 and $3,236,535, respectively)	7,483,029	6,010,709
Net other expense	(2,132,160)	(1,764,148)
Income before federal income tax expense	1,394,225,746	1,333,189,178
Federal income tax expense	254,188,788	441,483,780
Net income	$ 1,140,036,958	$ 891,705,398

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2018 and 2017

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2017	1,104,167	$ 8,833,336	$ -	$ 2,039,971,053	$ 2,175,934,933	$ 4,224,739,322
Net income	-	-	-	-	891,705,398	891,705,398
Projected HCRL fee assessment	-	-	474,068,972	-	(474,068,972)	-
Change in net unrealized capital gain, less capital gains tax of $0	-	-	-	-	18,326,818	18,326,818
Change in net deferred income taxes	-	-	-	-	(77,203,573)	(77,203,573)
Change in nonadmitted assets	-	-	-	-	11,108,106	11,108,106
Stock-based compensation	-	-	-	46,819,035	-	46,819,035
Correction of prior period error	-	-	-	-	(5,981,766)	(5,981,766)
Dividends or return of capital paid	-	-	-	-	(925,000,000)	(925,000,000)
Balances at December 31, 2017	1,104,167	8,833,336	474,068,972	2,086,790,088	1,614,820,944	4,184,513,340
Net income	-	-	-	-	1,140,036,958	1,140,036,958
HCRL fee moratorium	-	-	(474,068,972)	-	474,068,972	-
Gain on reinsurance	-	-	1,106,711	-	-	1,106,711
Change in net unrealized capital loss, less capital gains tax of $0	-	-	-	-	(171,565,548)	(171,565,548)
Change in net deferred income taxes	-	-	-	-	(50,745,131)	(50,745,131)
Change in nonadmitted assets	-	-	-	-	(55,990,938)	(55,990,938)
Other	-	-	-	(1,682,512)	-	(1,682,512)
Dividends or return of capital paid	-	-	-	-	(1,325,000,000)	(1,325,000,000)
Balances at December 31, 2018	1,104,167	$ 8,833,336	$ 1,106,711	$ 2,085,107,576	$ 1,625,625,257	$ 3,720,672,880

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2018 and 2017

	2018	2017
Cash flows from operations		
Premiums collected	$ 24,565,587,944	$ 23,194,176,144
Net investment income received	253,484,760	138,064,535
Benefits paid	(20,163,726,464)	(18,417,110,170)
Selling, general and administrative expenses paid	(4,050,218,668)	(1,518,825,239)
Federal income taxes paid	(333,698,015)	(455,918,596)
Net cash from operations	271,429,557	2,940,386,674
Cash flows from investments		
Proceeds from investments sold or matured	1,097,977,605	1,573,653,705
Cost of investments acquired	(1,949,262,605)	(2,079,022,642)
Net cash used for investments	(851,285,000)	(505,368,937)
Cash flows from financing and miscellaneous sources		
Dividends or return of capital paid	(1,325,000,000)	(925,000,000)
Other cash provided (applied)	117,953,282	(158,623,763)
Net cash used for financing and miscellaneous sources	(1,207,046,718)	(1,083,623,763)
Net change in cash, cash equivalents and short-term investments	(1,786,902,161)	1,351,393,974
Cash, cash equivalents and short-term investments		
Beginning of year	2,706,219,932	1,354,825,958
End of year	$ 919,317,771	$ 2,706,219,932

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

1. Reporting Entity

Humana Insurance Company (the Company), a wholly owned subsidiary of CareNetwork Inc., a wholly owned subsidiary of Humana Inc. (Humana), is a life, accident, and health insurance company domiciled in the state of Wisconsin and is authorized to sell life, accident and health products therein and in 49 states including the District of Columbia. The Company is subject to regulation by the federal government and the Wisconsin Office of the Commissioner of Insurance (the OCI) and the insurance departments of the states in which it is licensed. State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 9, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 8.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 13(a).

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the OCI, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(t), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Policy and contract liabilities are reported net of reinsurance ceded amounts and any gains from reinsurance transactions are included as a component of surplus, whereas under GAAP, assets and liabilities related to reinsurance ceded contracts are reported on a gross basis and reinsurance transaction gains are reported as a liability;

viii. Investments in subsidiaries are carried at their underlying statutory equity value with changes in value being recorded directly to surplus, whereas under GAAP, these subsidiaries would be consolidated;

ix. Comprehensive income disclosures required by GAAP are omitted; and

x. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

The OCI adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The OCI has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. No deviations from the Codification currently exist.

The preparation of the Company's financial statements requires management to make estimates and assumptions that affect (a) the reported amounts of assets and liabilities, (b) disclosure of contingent assets and liabilities at the date of the financial statements, and (c) reported amounts of revenues and expenses during the reporting period. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL 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 (MA) 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 HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee levied on the insurance industry is $14.3 billion in 2018, and is not deductible for income tax purposes, which significantly increases the Company's effective income tax rate. A one year suspension of the health insurance industry fee, as the Company experienced in 2017 and is experiencing in 2019, significantly impacts

the Company's trend in key operating metrics including the Company's operating cost and medical expense ratios, as well as its effective tax rate. The annual health insurance industry fee is scheduled to resume for calendar year 2020 under current law.

As noted above, the HCRL required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Although the Company previously participated in these exchanges by offering on-exchange individual commercial medical plans, effective January 1, 2018, the Company has exited its Individual Commercial medical business.

It is reasonably possible that the HCRL and related regulations, as well as future legislative, judicial or regulatory changes, including restrictions on Humana's ability to manage its provider network or otherwise operate its business, or restrictions on profitability, including reviews by regulatory bodies that may compare its MA profitability to its non-MA business profitability or compare the profitability of various products within its MA business, and require that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on Humana's results of operations, (including restricting premiums, enrollment and premium growth in certain products and market segments, restricting Humana's ability to expand into new markets, increasing its medical and operating costs, further lowering its Medicare payment rates and increasing its expenses associated with the non-deductible health insurance industry fee and other assessments); its financial position; and its cash flows. Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace HCRL or declare all or certain portions of the HCRL unconstitutional, creates uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

c. Cash and Cash Equivalents and Short-Term Investments: Investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. Investments: Bonds, including loan-backed and structured securities, with a NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest

related factors such as (a) the length of time and extent to which the fair value has been less than cost, (b) adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, (c) payment structure of the security, (d) changes in credit rating of the security by the rating agencies, (e) the volatility of the fair value changes, (f) changes in fair value of the security after the balance sheet date, and (g) the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as (a) the length of time and extent to which the fair value has been less than cost, (b) adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, (c) payment structure of the security, (d) changes in credit rating of the security by the rating agencies, (e) the volatility of the fair value changes, (f) changes in fair value of the security after the balance sheet date, and (g) cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2018 or December 31, 2017.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted. No portion of the investment income due and accrued was nonadmitted at December 31, 2018 or 2017.

For other restricted assets reported in aggregate, the pledged amounts with the OCI and other state departments of insurance were $11,003,049 and $11,299,988, which is 0.15% and 0.13%, of gross assets and 0.15% and 0.13%, of net admitted assets at December 31, 2018 and 2017, respectively.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

e. Fair Value: In accordance with SSAP No. 100, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2018 or 2017.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The fair value of financial assets carried at fair value at December 31, 2018 and 2017 were as follows:

	Fair Value Measurements at December 31, 2018			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	-	347,662	-	347,662
Corporate debt securities	-	136,046,067	-	136,046,067
Total invested assets	$ -	$ 136,393,729	$ -	$ 136,393,729

	Fair Value Measurements at December 31, 2017			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	-	498,897	-	498,897
Corporate debt securities	-	43,270,196	-	43,270,196
Total invested assets	$ -	$ 43,769,093	$ -	$ 43,769,093

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2018 and 2017 were as follows:

	December 31, 2018					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 4,278,164,081	$ 4,344,265,880	$ 579,191,533	$ 3,698,972,548	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 4,286,714,081	$ 4,352,815,880	$ 579,191,533	$ 3,698,972,548	$ 8,550,000	$ -

	December 31, 2017					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 5,858,903,247	$ 5,854,131,206	$ 2,459,047,304	$ 3,399,855,943	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 5,867,453,247	$ 5,862,681,206	$ 2,459,047,304	$ 3,399,855,943	$ 8,550,000	$ -

The Company reports transfers between fair value hierarchy levels at the end of the reporting period. There were no material transfers between the fair value hierarchy levels during 2018 or 2017.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

f. Real Estate and Long-Lived Assets: Real estate occupied by the Company is carried at the depreciated cost. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from ten to twenty years. Depreciation expense on real estate occupied by the Company was $1,671,048 and $1,665,205 for the years ended December 31, 2018 and 2017, respectively.

The Company periodically reviews long-lived assets, including property and equipment, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in the Company's operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. The Company recognizes an impairment loss based on the excess of the carrying value over the fair value of the asset. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, the Company periodically reviews the estimated lives of all long-lived assets for reasonableness.

g. Statutory Deposits: Investments, generally U.S. Treasury obligations, were on deposit at December 31, 2018 and 2017 to satisfy requirements of regulatory agencies. These assets are included in bonds in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

h. Investment in subsidiaries: In accordance with SSAP No. 97, *Investments in Subsidiary, Controlled, and Affiliated Entities,* a replacement of SSAP No. 88 (SSAP No. 97), $804,849,178 and $969,884,560 were admitted as investment in subsidiaries at December 31, 2018 and 2017, respectively. The Company owns 100% of the common stock of Humana Employers Health Plan of Georgia, Inc. (HEHPGA), Humana Insurance Company of Kentucky (HICK), and Humana Health Benefit Plan of Louisiana, Inc. (HHBPLA). The Company accounts for its investment in subsidiaries using the statutory equity method of accounting.

The Company reports an investment in an insurance subsidiary, HHBPLA, for which the audited statutory equity reflects a departure from the NAIC statutory accounting practices and procedures. The Commissioner of Insurance of the State of Louisiana allowed the Company to admit its $1,209,176 and $1,411,589 of furniture and equipment used for Health Maintenance Organization operations in 2018 and 2017, respectively, which is not in accordance with NAIC SSAP. Had HHBPLA not been allowed to admit these balances, the Company's ending surplus at December 31, 2018 and 2017 would have been $3,719,463,704 and $4,183,101,751, respectively. The Company's risk-based capital would have not triggered a regulatory event had it not used a prescribed or permitted practice.

i. Equipment: Equipment is recorded at cost less accumulated depreciation. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from three to ten years. Depreciation expense, including that related to the nonadmitted portion, was $23,084,740 and $15,776,198 for the years ended December 31, 2018 and 2017, respectively. Gains and losses on sales or disposals of property and equipment are included in net other expense in the accompanying statements of revenue and expenses.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements was $2,130,306 and $1,743,421 for the years ended December 31, 2018 and 2017, respectively.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

j. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates. Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2018 and 2017 DTAs of $10,324,167 and $17,111,568, respectively, were nonadmitted.

k. Earned Premiums: Premiums are reported as earned in the period in which members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS utilizes a risk adjustment model which apportions premiums paid to MA plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally, pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases payments on a comparison of beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. The Company generally relies on providers, including certain providers in its network who are Humana employees, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for payments received from CMS

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

under the actuarial risk-adjustment model. The Company also relies on providers to appropriately document all medical data, including the diagnosis data submitted with claims. The Company estimates risk-adjustment premiums based on medical diagnoses for its membership. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2017, 25% of the risk score was calculated from claims data submitted through EDS.

The amount of net premiums written by the Company in 2018 and 2017 that were subject to retrospective rating features were $23,661,513,742 and $21,999,856,694, respectively, or 95.33% and 95.98%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $508,696,324 and $273,456,682 as of December 31, 2018 and 2017, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS).

Pursuant to the HCRL, the Company recorded the following amounts at December 31, 2018 and 2017 for policyholder rebates:

	2018					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred	$ 2,446,421	$ 2,279,187	$ 3,858,865	$ 8,584,473	$ 11,017,026	$ 19,601,499
Medical loss ratio rebates paid	8,164,201	2,017,801	1,698,563	11,880,565	-	11,880,565
Medical loss ratio rebates unpaid	-	2,155,487	3,438,395	5,593,882	13,313,026	18,906,908

	2017					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred	$ 5,967,107	$ 1,666,514	$ 1,176,394	$ 8,810,015	$ 2,296,000	$ 11,106,015
Medical loss ratio rebates paid	1,078,318	1,879,474	2,391,754	5,349,546	60,957	5,410,503
Medical loss ratio rebates unpaid	5,717,780	1,894,101	1,278,093	8,889,974	2,296,000	11,185,974

The amounts recorded for the medical loss rebates incurred are recorded as a reduction of premium in earned premiums in the accompanying statutory statements of revenue and expenses. The medical loss rebates unpaid are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus. Medical loss ratio

rebates that were accrued at December 31, 2017, were ultimately settled during 2018 for $694,591 more than the amounts originally estimated.

There is no impact of any reinsurance assumed or ceded on the medical loss ratio rebate.

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

The risk corridor provisions compare costs targeted in the Company's 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 the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately nine months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The

Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2018 and 2017:

	2018		2017	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 1,301,107	$ -	$ 4,117,723	$ -
Amounts receivable relating to uninsured plans	-	132,885,205	-	66,072,465
Aggregate health policy reserves	(122,601,698)	-	(187,549,955)	-
Accounts payable and accrued expenses	-	(318,043,557)	-	(769,443,901)
Net liability	$ (121,300,591)	$ (185,158,352)	$ (183,432,232)	$ (703,371,436)

m. Accounting for the Risk-Sharing Provisions of the Health Care Reform Law: Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

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

estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company's risk adjustment data for 2017 was selected for audit by HHS.

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

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2018 and 2017:

HCRL Risk Adjustment		
Assets	**2018**	**2017**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 479,212	$ 18,459,737
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	212,053	313,059
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	3,423,961	8,359,869
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	(2,703,376)	9,020,970
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	162,910	324,079

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

HCRL Risk Corridor

Assets	**2018**	**2017**
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	158,361	179,955
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 18,114,801	$ 15,081,396	$ 3,033,405	$ -	$ -	$ -
2015	17,262,163	17,262,163	-	-	-	-
2016	11,060,900	11,060,900	-	-	-	-
Total	$ 46,437,864	$ 43,404,459	$ 3,033,405	$ -	$ -	$ -

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

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the transitional HCRL reinsurance program as of December 31, 2018 and 2017:

	2018	2017
Assets		
Amounts recoverable for claims paid due to HCRL Reinsurance	$ -	$ 10,972,182
Amounts recoverable for claims unpaid due to HCRL Reinsurance (Contra Liability)	-	-
Amounts receivable relating to uninsured plans for contributions for HCRL Reinsurance	-	-
Liabilities		
Liabilities for contributions payable due to HCRL Reinsurance – not reported as ceded premium	-	-
Ceded reinsurance premiums payable due to HCRL Reinsurance	-	-
Liabilities for amounts held under uninsured plans contributions for HCRL Reinsurance	-	-
Operations (Revenues & Expenses)		
Ceded reinsurance premiums due to HCRL Reinsurance	-	-
Reinsurance recoveries (income statement) due to HCRL Reinsurance payments or expected payments	14,415	16,445,028
HCRL Reinsurance contributions – not reported as ceded premiums	-	-

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal government of $43,404,459 in payments for the Company under the risk corridor premium stabilization program established under the HCRL, for the years 2014, 2015 and 2016. Humana's case has been stayed by the Court, pending resolution of similar cases filed by other insurers.

In addition to the provisions discussed above, beginning in 2014, HHS paid the Company a portion of the health care costs for low-income individual members for which the Company assumes no risk in accordance with the HCRL. These cost subsidy payments ceased effective October 2017. The Company accounted for these subsidies as a deposit in its statutory statements of admitted assets, liabilities and surplus and as an operating activity in its statements of cash flows. The Company did not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies. Receipt and payment activity was accumulated at the state level and recorded in its statutory statements of admitted assets, liabilities and surplus in health care and other receivables or accounts payable and accrued expenses depending on the state balance at the end of the reporting period.

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	18,459,737		15,953,707		2,506,030		(2,517,587)		A.	(11,557)	
2. Premium adjustments (payables) (including high risk pool payments)		(8,359,869)		(5,612,466)		(2,747,403)		2,747,403	B.		-
3. Subtotal ACA Permanent Risk Adjustment Program	18,459,737	(8,359,869)	15,953,707	(5,612,466)	2,506,030	(2,747,403)	(2,517,587)	2,747,403		(11,557)	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	10,972,182		10,986,597		(14,415)		14,415		C.	-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance-not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	10,972,182	-	10,986,597	-	(14,415)	-	14,415	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		158,361		(158,361)		158,361		D.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	158,361	-	(158,361)	-	158,361	-		-	-
d. Total for ACA Risk Sharing Provisions	29,431,919	(8,359,869)	27,098,665	(5,612,466)	2,333,254	(2,747,403)	(2,344,811)	2,747,403		(11,557)	-

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

Explanation for adjustments

A. Adjustments recorded to the 2017 risk adjustment receivable to align with the CMS payment report.

B. Adjustments recorded to the 2017 risk adjustment payable to align with the CMS payment report.

C. Adjustments recorded to the 2017 reinsurance receivable to align with the CMS payment report.

D. Adjustments recorded for additional risk corridor payments received in 2018 that had been previously written off.

Net collections under the 3Rs associated with prior coverage years were $21,486,199 and $118,071,754 in 2018 and 2017, respectively. The Company collected all reinsurance recoverables relating to prior coverage years in 2018.

A roll-forward of risk corridor assets, gross of any nonadmissions and liability balances by program year, along with the reasons for adjustments to prior year balances are presented below.

		Accrued as of December 31 of the Prior Reporting Year		Received or Paid as of the Current Period on Business Written for the Risk Corridors Program Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
						Accrued Less Payments (Col 1 -3)	Accrued Less Payments (Col 2 -4)				Cumulative Balance (Col 1-3+7)	Cumulative Balance (Col 4-4+8)
		1	2	3	4	5	6	7	8		9	10
	Risk Corridors Program Year	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
2014	Accrued retrospective premium	-		158,361		(158,361)		158,361		A.	-	
	Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
2015	Accrued retrospective premium	-		-		-		-			-	
	Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
2016	Accrued retrospective premium	-		-		-		-			-	
	Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
	Total for Risk Corridors	-	-	158,361	-	(158,361)	-	158,361	-		-	-

Explanation for adjustments

A. Adjustments recorded for additional risk corridor payments received in 2018 that had been previously written off.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

n. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 10. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2018, 2017, and 2016:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days After Billing
12/31/2018	$ 871,791,853	$ 871,791,853	$ -	$ -	$ -
9/30/2018	1,019,941,316	1,019,941,316	1,016,254,784	-	-
6/30/2018	1,351,608,731	1,351,608,731	1,346,148,031	5,460,700	-
3/31/2018	914,970,239	914,970,239	914,970,239	-	-
12/31/2017	792,665,292	792,665,292	748,733,774	42,233,855	1,697,663
9/30/2017	839,797,724	839,797,724	839,456,062	-	341,662
6/30/2017	803,680,635	803,680,635	802,965,453	607,609	107,573
3/31/2017	831,181,809	831,181,809	831,166,820	-	14,989
12/31/2016	624,000,033	624,000,033	623,934,067	65,966	1,572,626
9/30/2016	631,616,885	631,616,885	631,594,994	-	21,891
6/30/2016	553,580,145	553,580,145	552,819,669	-	760,476
3/31/2016	515,521,963	515,521,963	515,243,619	-	278,344

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $3,686,532 and $449,235 were nonadmitted at December 31, 2018 and 2017, respectively.

o. Risk-Share Agreements: The Company negotiates contractual agreements with group Medicare customers, some of which contain gain sharing provisions in the event the benefit ratio is less than an agreed-upon level. In these agreements, the Company and the customers generally share evenly in the gain. The Company recorded gain share payable of $8,292,453 and $30,534,625 as of December 31, 2018 and 2017, respectively, which is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

p. Benefits Incurred and Loss Adjustment Expenses: Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug

manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $2,189,000 at December 31, 2018 but none were recorded at December 31, 2017. The liability at December 31, 2018 is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

q. Reserves for Life Contracts and Deposit-Type Contracts: The Company waives the deduction of deferred fractional premiums upon death of the insured and holds net level or modified premium reserves on mortality and interest bases that are consistent with statutory guidance. The Company does not return any portion of the final premium for periods beyond the date of death. Surrender values are not promised in excess of the legally computed reserves.

As of December 31, 2018 and 2017 the Company did not have any life insurance in force for which the gross premiums were less than the net premiums according to the standard valuation

set by the OCI, as described in SSAP No. 51, *Life Contracts* (SSAP No. 51). As discussed in Note 10, all non-health insurance business, including all associated reserves, was ceded to HICK as of January 1, 2013.

r. Administrative Service Only Contracts (ASO): Administrative services fees cover the processing of claims, offering access to the Company's provider networks and clinical programs and responding to customer service inquiries from members of self-funded groups. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from Humana to cover catastrophic claims or to limit aggregate annual costs. The Company does not reflect payment of ASO claims in its statutory statements of revenue and expenses.

s. Mortgage Loans: Mortgage loans are current and carried at unpaid principal balances, net of discounts/premiums and valuation allowances. The Company has estimated the book/adjusted carrying value of its mortgage loans, to be $8,550,000 at December 31, 2018 and 2017. This estimate was established using a discounted cash flow method based on rating, maturity and future income when compared to the expected yield for mortgages having similar characteristics. The rating for mortgages in good standing is based on property type, location, market conditions, occupancy, debt service coverage, loan to value, caliber of tenancy, borrower and payment record. Problem mortgages are priced to reflect their monetary value to the Company, considering such things as the degree of default, whether or not the payments are still being made, interest rate, maturity and operating performance of the underlying collateral.

During 2018 and 2017, the maximum and minimum lending rates for mortgage loans were 6.65% at both year ends. At the issuance of a loan, the percentage of loan to value on any one loan does not exceed 100.

t. Nonadmitted Assets: Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, furniture and equipment, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

u. Going Concern Considerations: Effective December 31, 2016, the Company adopted revisions to SSAP No. 1, *Disclosure of Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). The revisions require management of the Company to evaluate whether there is substantial doubt about the Company's ability to continue as a going concern and provide certain disclosures if substantial doubt exists. Management of the Company has completed its evaluation of the Company and determined that there is no substantial doubt about its ability to continue as a going concern.

v. Subsequent Events: The Company evaluated subsequent events through April 29, 2019, the date these financial statements were issued or available to be issued.

On January 1, 2019, the Company will not be subject to the annual fee under Section 9010 of the Federal HCRL as described in Note 2(b). The Consolidated Appropriations Act enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year

suspension in 2019 of the health insurer fee, but the fee is scheduled to resume in calendar year 2020. Based on the moratorium no segregation was recorded within special surplus for the annual health insurance industry fee related to the 2018 data year. In 2018, the Company was subject to an annual fee under section 9010 of the Federal HCRL. This annual fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. The 2018 fee was included in 2017 special surplus and paid September 30, 2018. The impact of the annual health insurance industry fee on the Company's operations as of December 31, 2018 and 2017 were as follows:

	2018	2017
HCRL fee assessment payable	$ -	$ 474,068,972
HCRL fee assessment paid	465,787,513	-
Premium written subject to HCRL 9010 assessment	-	22,596,604,285
Total Adjusted Capital Level before surplus adjustment	3,721,217,981	4,184,921,607
Total Adjusted Capital Level after surplus adjustment	3,721,217,981	3,710,852,635
Authorized Control Level after surplus adjustment	911,846,230	804,955,561

On March 26, 2019 the Company requested to pay a dividend to its parent Humana of $575,000,000 of which all was extraordinary. The Company received approval to pay the dividend from the OCI on April 24, 2019. The Company has not yet paid the dividend.

The Company is not aware of any other events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements which may have a material effect on its financial condition.

3. Correction of Prior Period Errors

In April of 2017, the Company determined that two ongoing provider disputes related to plan year 2017 would result in additional claims of $8,933,927. This resulted in the 2017 benefits and loss adjustment expenses payable to be understated by $8,933,927. The income statement, within benefits incurred and loss adjustment expenses, was also understated by $8,933,927 and federal and state taxes were overstated by $2,952,161. Consistent with SSAP No. 3, *Accounting Changes and Corrections of Errors* (SSAP No. 3), the net impact of the claims dispute for 2016 after the tax impact was recorded as an adjustment to unassigned surplus. The full amount of the 2016 disputed claims was settled during the second quarter of 2017.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

4. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2018 and 2017 were as follows:

	2018			
	Book/ Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 45,220,981	$ 2,270	$ (1,350,214)	$ 43,873,037
States, territories and possessions	376,467,263	133,524	(4,760,328)	371,840,459
Political subdivisions of states, territories and possessions	18,807,835	-	(87,537)	18,720,298
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,339,785,888	1,212,255	(22,068,751)	1,318,929,392
Industrial and miscellaneous	1,766,934,171	463,605	(39,646,646)	1,727,751,130
Total bonds	$ 3,547,216,138	$ 1,811,654	$ (67,913,476)	$ 3,481,114,316

	2017			
	Book/ Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 103,490,746	$ 24,423	$ (730,859)	$ 102,784,310
States, territories and possessions	497,081,891	4,034,194	(3,445,909)	497,670,176
Political subdivisions of states, territories and possessions	40,264,322	81,425	(495,112)	39,850,635
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,121,442,045	9,015,123	(7,999,652)	1,122,457,516
Industrial and miscellaneous	1,410,280,230	12,635,911	(8,347,503)	1,414,568,638
Total bonds	$ 3,172,559,234	$ 25,791,076	$ (21,019,035)	$ 3,177,331,275

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The book/adjusted carrying value and estimated fair value of bonds and short-term investments at December 31, 2018, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 372,655,184	$ 371,991,020
Due after one year through five years	1,004,660,451	986,250,475
Due after five years through ten years	632,563,473	612,968,314
Due after ten years	278,877,908	273,859,752
Mortgage and asset-backed securities	1,476,317,332	1,453,902,987
	$ 3,765,074,348	$ 3,698,972,548

The detail of realized gains (losses) of bonds for the years ended December 31, 2018 and 2017 were as follows:

	2018	2017
Gross realized gains	$ 12,051,356	$ 11,963,687
Gross realized losses	(2,486,332)	(2,888,522)
Net realized gains	$ 9,565,024	$ 9,075,165

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2018 and 2017 were as follows:

	2018					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 3,467,242	$ (4,297)	$ 39,833,832	$ (1,345,917)	$ 43,301,074	$ (1,350,214)
States, territories and possessions	104,923,870	(1,126,095)	245,329,916	(3,634,233)	350,253,786	(4,760,328)
Political subdivisions of states, territories and possessions	10,508,908	(51,453)	8,211,390	(36,084)	18,720,298	(87,537)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	553,821,700	(8,066,377)	536,624,678	(14,002,374)	1,090,446,378	(22,068,751)
Industrial and misc.	963,697,674	(16,963,682)	529,889,721	(22,682,964)	1,493,587,394	(39,646,646)
Total invested assets	$ 1,636,419,395	$ (26,211,904)	$,359,889,536	$ (41,701,572)	$ 2,996,308,931	$ (67,913,476)

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

	2017					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 7,710,933	$ (52,360)	$ 44,041,757	$ (678,499)	$ 51,752,690	$ (730,859)
States, territories and possessions	192,251,227	(1,848,064)	113,456,908	(1,597,845)	305,708,135	(3,445,909)
Political subdivisions of states, territories and possessions	8,465,207	(16,455)	20,504,510	(478,657)	28,969,716	(495,112)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	276,542,352	(1,475,307)	371,801,258	(6,524,345)	648,343,611	(7,999,652)
Industrial and misc.	390,702,463	(3,368,340)	180,857,985	(4,979,163)	571,560,448	(8,347,503)
Total invested assets	$ 875,672,182	$ (6,760,526)	$ 730,662,418	$ (14,258,509)	$ 1,606,334,600	$ (21,019,035)

The unrealized loss from all securities was generated from 575 investment positions at December 31, 2018. All issuers of securities the Company owns that were trading at an unrealized loss at December 31, 2018 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2018, the Company did not intend to sell the securities with an unrealized loss position, and it is not likely that the Company will be required to sell these securities before recovery of their amortized cost basis. As a result, the Company believes that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2018. Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

5. Reinsurance

The Company reinsures portions of its business through various reinsurance treaties. These treaties protect the Company from sustaining losses above predetermined levels and are included as a reduction of earned premiums in the accompanying statements of revenue and expenses. Although the reinsurer in each case is primarily liable on the insurance ceded, the Company remains liable to the insured whether or not the reinsurer meets its contractual obligations.

Effective August 3, 2018, retroactive to January 1, 2018, the company entered into a 100% Indemnity Coinsurance Assumed agreement with Kanawha Insurance Company (KIC), a related party at the time. Under the terms of the contract, the Company assumed the group life and disability policies of KIC. Effective August 9, 2018, pursuant to the Stock Purchase Agreement signed on November 6, 2017 between Humana and Continental General Insurance Company, KIC was sold and no longer affiliated with the Company. For the year ended December 31, 2018, there were $4,619,770 premiums assumed related to this agreement. Total reserves assumed were $492,591 for the year ended December 31, 2018.

Effective June 29, 2018 and August 3, 2018, retroactive to January 1, 2018, the Company entered into 100% Indemnity Coinsurance and Assumption reinsurance agreements with ManhattanLife Assurance Company of America and Manhattan Life Insurance Company, respectively, both are unrelated entities. Under the terms of the contracts, the Company ceded its individual life, annuity and supplemental health products such as cancer, critical illness, hospital indemnity and accident

policies. Initial policy and claim reserves transferred were $18,893,620. For the year ended December 31, 2018 there were $6,181,779 premiums ceded related to this agreement. Total reserves ceded were $11,993,284 for the year ended December 31, 2018.

The Company has other reinsurance contracts with various insurers and affiliates as noted within Note 10. For the years ended December 31, 2018 and 2017 there were $93,605,469 and $84,969,490 premiums ceded, respectively, related to these contracts. For the year ended December 31, 2017 there were $98,914 premiums assumed related to these contracts. No additional premiums were assumed in 2018.

In 2018 and 2017, the Company did not commute any ceded reinsurance, nor did it enter into or engage in any agreement that reinsures policies or contracts that were in-force or had existing reserves as of the effective date of such agreements. No write-offs of reinsurance balances occurred in 2018 or 2017. The Company remains obligated for amounts ceded in the event that reinsurers do not meet their obligations.

The Company has not entered into any reinsurance agreements in which the reinsurer may unilaterally cancel any reinsurance for reasons other than nonpayment of premiums or other amounts due. The Company does not have any reinsurance agreements in effect in which the amount of losses paid or accrued through December 31, 2018 or 2017 would result in a payment to the reinsurer of amounts which, in the aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premiums collected under the reinsured policies.

6. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2018 and 2017 were as follows:

	2018		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 88,121,826	$ 1,743,476	$ 89,865,302
Statutory valuation allowance adjustment	-	(1,743,476)	(1,743,476)
Adjusted gross deferred tax assets	88,121,826	-	88,121,826
Deferred tax assets nonadmitted	(10,324,167)	-	(10,324,167)
Subtotal net admitted deferred tax assets	77,797,659	-	77,797,659
Gross deferred tax liabilities	(3,164,722)	-	(3,164,722)
Net admitted deferred tax asset/(liability)	$ 74,632,937	$ -	$ 74,632,937

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

	2017		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 138,964,193	$ 855,129	$ 139,819,322
Statutory valuation allowance adjustment	-	(855,129)	(855,129)
Adjusted gross deferred tax assets	138,964,193	-	138,964,193
Deferred tax assets nonadmitted	(17,111,568)	-	(17,111,568)
Subtotal net admitted deferred tax assets	121,852,625	-	121,852,625
Gross deferred tax liabilities	(3,261,958)	-	(3,261,958)
Net admitted deferred tax asset/(liability)	$ 118,590,667	$ -	$ 118,590,667

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2018 and 2017 were as follows:

	December 31, 2018		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 72,580,190	$ -	$ 72,580,190
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	2,052,747	-	2,052,747
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	2,052,747
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	538,775,017
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	3,164,722	-	3,164,722
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 77,797,659	$ -	$ 77,797,659

	December 31, 2017		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 109,188,343	$ -	$ 109,188,343
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	9,402,324	-	9,402,324
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	9,402,324
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	602,770,605
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	3,261,958	-	3,261,958
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 121,852,625	$ -	$ 121,852,625

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2018	2017
Ratio percentage used to determine recovery period and threshold limitation amount	394%	499%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 3,591,833,447	$ 4,018,470,701

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2018 and 2017 consisted of the following:

	2018	2017
Current year income tax provision	$ 297,497,046	$ 442,334,855
Revisions in prior years' estimated taxes	(43,308,258)	(851,075)
Federal income tax expense excluding the tax on realized capital gains and before change in net deferred income taxes	254,188,788	441,483,780
Tax on realized capital gains	1,989,160	3,236,535
Change in net deferred income taxes	50,745,131	77,203,573
Correction of prior period error	-	(2,712,473)
Total statutory income taxes	$ 306,923,079	$ 519,211,415

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2018 and 2017 were as follows:

	2018	2017	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 27,379,248	$ 37,585,492	$ (10,206,244)
Advance premiums	4,603,496	4,983,584	(380,088)
Policyholder reserves	169,581	580,934	(411,353)
Investments	-	-	-
Deferred acquisition costs	18,214,629	41,012,147	(22,797,518)
Policyholder dividends accrual	-	-	-
Fixed assets	-	-	-
Compensation and benefit accruals	18,882,304	39,332,433	(20,450,129)
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	108,996	196,662	(87,666)
Bad debts	1,778,087	1,079,763	698,324
Accrued litigation	43,470	204,435	(160,965)
CMS Rx reserves	15,255,850	9,925,224	5,330,626
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	362,960	2,955,942	(2,592,982)
Accrued lease	824,602	651,676	172,926
Section 197 intangibles	335,359	369,755	(34,396)
Reinsurance fee	-	-	-
Provider contracts	163,244	86,146	77,098
Gross ordinary DTAs	88,121,826	138,964,193	(50,842,367)
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(10,324,167)	(17,111,568)	6,787,401
Admitted ordinary DTAs	77,797,659	121,852,625	(44,054,966)
Capital			
Investments	1,743,476	855,129	888,347
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	1,743,476	855,129	888,347
Statutory valuation allowance adjustment	(1,743,476)	(855,129)	(888,347)
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 77,797,659	$ 121,852,625	$ (44,054,966)

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

	2018	2017	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	(56,361)	(3,169,494)	3,113,133
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(77,679)	(92,464)	14,785
CMS RX Reserve	-	-	-
Reserve Transition Adjustment	(3,030,682)	-	(3,030,682)
Ordinary DTLs	(3,164,722)	(3,261,958)	97,236
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(3,164,722)	(3,261,958)	97,236
Net deferred tax assets/(liabilities)	$ 74,632,937	$ 118,590,667	$ (43,957,730)

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the ordinary portion of the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no ordinary DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from. A statutory valuation allowance has been set up for deferred taxes on future capital loss items, due to uncertainty regarding the timing of their reversal.

The tax reform law enacted on December 22, 2017 (the Tax Reform Law) reduced the statutory federal corporate income tax rate to 21 percent from 35 percent, beginning in 2018. The rate reduction required a remeasurement of the Company's net deferred tax asset. The impact on December 31, 2017 surplus was as follows:

	Surplus Impact
Tax Reform Effect on Operations	$ (90,468,156)
Tax Reform Effect on Deferred Taxes Non-Admitted	11,407,712
Tax Reform Effect on Unrealized Gains and Losses	-
Total Impact of Tax Reform	$ (79,060,444)

Revisions in 2018 to the Company's prior estimate for the effects of the Tax Reform Law were not material to the financial statements. This completes the Company's accounting related to Tax Reform.

The change in nonadmitted deferred tax assets from December 31, 2017 to 2018 was a decrease of $6,787,401. The change in nonadmitted deferred tax assets from December 31, 2016 to 2017 was a decrease of $20,408,098.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

HCRL fee, dividends received deduction and change to nonadmitted assets & deferred tax true-ups in 2018.

The Company had no net operating loss carryforwards at December 31, 2018 or 2017.

The following table demonstrates the income tax expense for 2017 and 2018 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2017	396,314,124	3,236,535	399,550,659
2018	297,497,046	1,989,160	299,486,206
	$ 693,811,170	$ 5,225,695	$ 699,036,865

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2018 or 2017.

As of December 31, 2018, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana’s consolidated income tax returns for 2017 and prior years. Humana’s 2018 tax return is under advance review by the IRS under the Compliance Assurance Process. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2018 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2018
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	AMERICAN ELDERCARE, INC.	65-0380198
6	ARCADIAN HEALTH PLAN, INC.	20-1001348
7	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
8	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
9	CARENETWORK, INC.	39-1514846
10	CAREPLUS HEALTH PLANS, INC.	59-2598550
11	CARITEN HEALTH PLAN INC.	62-1579044
12	CHA HMO, INC.	61-1279717
13	CHA SERVICE COMPANY, INC.	61-1279716
14	COMPBENEFITS COMPANY	59-2531815
15	COMPBENEFITS CORPORATION	04-3185995
16	COMPBENEFITS DENTAL, INC.	36-3686002
17	COMPBENEFITS DIRECT, INC.	58-2228851
18	COMPBENEFITS INSURANCE COMPANY	74-2552026
19	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
20	CONTINUCARE CORPORATION	59-2716023
21	CONTINUCARE MEDICAL MANAGEMENT, INC.	65-0791417
22	CONTINUCARE MSO, INC.	65-0780986
23	DEFENSEWEB TECHNOLOGIES, INC.	33-0916248
24	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
25	DENTICARE, INC.	76-0039628
26	EMPHESYS INSURANCE COMPANY	31-0935772
27	EMPHESYS, INC.	61-1237697
28	FAMILY PHYSICIANS OF WINTER PARK, INC.	59-3164234
29	FPG ACQUISITION CORP.	81-3802918
30	FPG ACQUISITION HOLDINGS CORP.	81-3819187
31	FPG HOLDING COMPANY, LLC	32-0505460
32	HARRIS, ROTHENBERG INTERNATIONAL, INC.	27-1649291

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

33	HEALTH VALUE MANAGEMENT, INC.	61-1223418
34	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
35	HUMANA AT HOME (DALLAS), INC.	75-2739333
36	HUMANA AT HOME (HOUSTON), INC.	76-0537878
37	HUMANA AT HOME (MA), INC.	04-3580066
38	HUMANA AT HOME (SAN ANTONIO), INC.	01-0766084
39	HUMANA AT HOME (TLC), INC.	75-2600512
40	HUMANA AT HOME 1, INC.	65-0274594
41	HUMANA AT HOME, INC.	13-4036798
42	HUMANA BEHAVIORAL HEALTH, INC.	75-2043865
43	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
44	HUMANA DENTAL COMPANY	59-1843760
45	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
46	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
47	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
48	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
49	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
50	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
51	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
52	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
53	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632
54	HUMANA HEALTH PLAN, INC.	61-1013183
55	HUMANA HEALTHCARE RESEARCH, INC. (f/k/a COMPREHENSIVE HEALTH INSIGHTS, INC.)	42-1575099
56	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
57	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
58	HUMANA INSURANCE COMPANY	39-1263473
59	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
60	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
61	HUMANA MARKETPOINT, INC.	61-1343508
62	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
63	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
64	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
65	HUMANA MEDICAL PLAN, INC.	61-1103898
66	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
67	HUMANA PHARMACY, INC.	61-1316926
68	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
69	HUMANA VETERANS HEALTHCARE SERVICES, INC.	20-8418853
70	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
71	HUMANADENTAL INSURANCE COMPANY	39-0714280
72	HUMANADENTAL, INC.	61-1364005
73	HUMCO, INC.	61-1239538
74	HUM-e-FL, INC.	61-1383567
75	KANAWHA INSURANCE COMPANY	57-0380426
76	KMG AMERICA CORPORATION	20-1377270
77	MANAGED CARE INDEMNITY, INC.	61-1232669
78	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
79	METCARE OF FLORIDA, INC.	65-0879131

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

80	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
81	PARTNERS IN INTEGRATED CARE, INC.	47-2905609
82	PARTNERS IN PRIMARY CARE (GA), P.C.	83-2624178
83	PARTNERS IN PRIMARY CARE (KS), P.A.	82-2000699
84	PARTNERS IN PRIMARY CARE (NC), P.C.	82-1926920
85	PARTNERS IN PRIMARY CARE, P.A.	47-1161014
86	PHP COMPANIES, INC.	62-1552091
87	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
88	PRESERVATION ON MAIN, INC.	20-1724127
89	PRIMARY CARE HOLDINGS, INC.	46-1225873
90	ROHC, LLC	75-2844854
91	SENIORBRIDGE (NC), INC.	56-2593719
92	SENIORBRIDGE CARE MANAGEMENT, INC.	80-0581269
93	SENIORBRIDGE FAMILY COMPANIES (AZ), INC.	46-0702349
94	SENIORBRIDGE FAMILY COMPANIES (CA), INC.	45-3039782
95	SENIORBRIDGE FAMILY COMPANIES (CT), INC.	27-0452360
96	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
97	SENIORBRIDGE FAMILY COMPANIES (IL), INC.	02-0660212
98	SENIORBRIDGE FAMILY COMPANIES (MD), INC.	81-0557727
99	SENIORBRIDGE FAMILY COMPANIES (MO), INC.	46-0677759
100	SENIORBRIDGE FAMILY COMPANIES (NJ), INC.	36-4484449
101	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
102	SENIORBRIDGE FAMILY COMPANIES (OH), INC.	20-0260501
103	SENIORBRIDGE FAMILY COMPANIES (PA), INC.	38-3643832
104	SENIORBRIDGE FAMILY COMPANIES (VA), INC.	46-0691871
105	TEXAS DENTAL PLANS, INC.	74-2352809
106	THE DENTAL CONCERN, INC.	52-1157181
107	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
108	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
109	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105
110	TRANSCEND INSIGHTS, INC.	80-0072760
111	TRANSCEND POPULATION HEALTH MANAGEMENT, LLC	46-5329373

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

7. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2018 and 2017 are summarized as follows:

	2018	2017
Balance at January 1,	$ 2,033,585,308	$ 1,706,703,563
Benefits incurred and loss adjustment expenses related to		
Current year	21,281,912,024	19,777,062,324
Prior year	(193,737,626)	(228,650,838)
	21,088,174,398	19,548,411,486
Benefits and loss adjustment expenses paid related to		
Current year	19,411,499,315	17,774,707,325
Prior year	1,507,817,957	1,446,822,416
	20,919,317,272	19,221,529,741
Balance at December 31,	$ 2,202,442,434	$ 2,033,585,308

Benefits and loss adjustment expenses payable at December 31, 2017 and 2016 ultimately settled during 2018 and 2017 for $193,737,626 and $228,650,838 less, respectively, than the amounts originally estimated as a result of favorable developments of unpaid claims and claim adjustment expenses principally on Medicare operations. These favorable developments were generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. The Company did not record any adjustments to premiums related to prior period claims development.

8. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the OCI statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the OCI is the lesser of 10% of total surplus or net gain from operations from the prior year. Based on these restrictions, the Company could have paid a maximum dividend to shareholders of approximately $418,400,000 in 2018 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. As shown in the table below, dividends paid in 2018 were deemed extraordinary as two dividends were paid in one year. Extraordinary amounts have been approved by the Department.

	Dividend or Return of Capital Amount		
	Ordinary	Extraordinary	Date Paid
Dividend	$ -	$ 975,000,000	April 20, 2018
Dividend	-	350,000,000	December 19, 2018
Total paid in 2018	$ -	$ 1,325,000,000	
Dividend	$ 422,400,000	$ 502,600,000	June 1, 2017
Total paid in 2017	$ 422,400,000	$ 502,600,000	

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

9. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Wisconsin has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $911,846,230 or the Company, under the discretion of the Commissioner of the OCI, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Wisconsin which require a minimum capital and surplus level of $3,200,355,060 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $3,720,672,880 and $4,184,513,340 as of December 31, 2018 and 2017, respectively.

10. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $5,036,781 and $3,867,589 for the years ended December 31, 2018 and 2017, respectively.

Employees of the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2018 and 2017 total allocated expenses associated with these plans were $20,266,799 and $18,906,296, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2018 and 2017 were $(71,865,173) and $237,525,108, respectively. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 6, which were $292,138,030 and $472,626,118 for the years ended December 31, 2018 and 2017, respectively. These amounts are net of fees received for services provided to wholly owned subsidiaries of Humana whereby the Company provides claims processing, billing and enrollment and other services as required by the subsidiaries. These amounts are allocated to the affiliates using a method that approximates an amount as if the expense had been incurred solely by the affiliates. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $64,578,016 and $275,574,930 due from Humana at December 31, 2018 and 2017, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

HPS, an affiliated entity, has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in healthcare and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(n) for further consideration of related pharmacy rebates.

The Company received no capital contributions in the years ended December 31, 2018 or 2017.

Effective January 1, 2013, the Company signed a reinsurance agreement with HICK, an affiliated entity. Under terms of the contract, the Company ceded all non-health insurance business including all of its individual and group life, annuity, deposit-type contracts, specified disease, disability income, accident or accidental death and dismemberment, and hospital indemnity insurance business. For the year ended December 31, 2018 and 2017 there were $26,637,618 and $28,977,431 premiums ceded, respectively, related to this agreement.

11. Employee Benefit Plans

The Company's employees are eligible to participate in the Humana Retirement Savings Plan (the Plan), a defined contribution plan, sponsored by Humana. The Plan maintains two accounts, the Savings Account and the Retirement Account. Humana's total contributions paid to the Plan were $194,704,927 and $216,450,717 for the years ended December 31, 2018 and 2017, respectively. Of these contributions, the Company contributed $93,255,484 and $82,798,712 during 2018 and 2017, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses. As of December 31, 2018 and 2017, the fair market value of the Humana Retirement Savings Plan's assets were $4,284,204,823 and $4,638,342,913, respectively.

12. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to five years. Operating lease rental payments charged to expenses for the years ended December 31, 2018 and 2017 was $19,852,732 and $20,149,695, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

In 2017 the Company terminated lease agreements early resulting in the recognition of a liability included within accounts payable and accrued expenses within the accompanying statements of admitted assets, liabilities and surplus. The following table includes the leases terminated and the related liability remaining at December 31, 2018 and 2017:

	2018	2017
Memphis TN	$ 8,032	$ 100,371
Keystone Crossing Office Park	-	63,022
NYC Regus	-	38,018
Total liability	$ 8,032	$ 201,411

Future minimum rental payments required under operating leases as of December 31, 2018, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2019	$	15,320,117
2020		13,165,612
2021		11,258,216
2022		5,523,153
2023		1,375,948
Thereafter		-
Total minimum lease payments	$	46,643,046

13. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $22,195,966,618 and $19,719,985,594 for the years ended December 31, 2018 and 2017, respectively. The loss of the Contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2019, and all product offerings filed with CMS for 2019 have been approved.

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

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

CMS is phasing-in the process of calculating risk scores using diagnoses data from the RAPS to diagnoses data from the EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on the Company's results of statutory statements of revenue and expenses, changes in surplus, or cash flows.

CMS and the Office of the Inspector General of Health and Human Services (HHS-OIG) are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for payment years 2012 and 2014.

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2014. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana is studying the Proposed Rule and CMS' underlying analysis contained therein. Humana believes, however, that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and expects to provide substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Humana is also evaluating the potential impact of the Proposed Rule, and any related regulatory, industry or company reactions, all or any of which could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus, or cash flows.

Humana believes that, CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS' final rule release regarding MA and Part D prescription drug benefit program regulations for Contract Year 2015 (referred to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each MA risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has filed a motion for reconsideration related to certain aspects of the Federal District Court's opinion and has simultaneously filed a notice to appeal the decision to the Circuit Court of Appeals.

The Company 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 the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows.

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

b. Legal Proceedings: During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus, and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus, and cash flows, and may also affect the Company's reputation.

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

c. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

d. Securities & Credit Markets Risks: Volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. There is a continuing risk that declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

e. Penn Treaty: Penn Treaty is a financially distressed unaffiliated long-term care insurance company. On March 1, 2017, the Pennsylvania Commonwealth Court approved the liquidation

of Penn Treaty. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, the Company may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as the Company. This court ruling triggered a guaranty fund assessment for the Company in the first quarter of 2017. Based on current information, the assessment is estimated at approximately $37,040,718 with a remaining unpaid balance as of December 31, 2018 of $14,092,491 included in accounts payable and accrued expenses in the accompanying statements of admitted assets, liabilities and surplus. The Company has also recognized an asset for premium tax credits associated with the assessment at December 31, 2018 and 2017 of $14,213,948 and $16,748,143, respectively, which are expected to be realized over the next 20 years. While the ultimate payment timing and associated recovery is currently unknown, the Company anticipates that the majority of the assessments will be paid within the next 5 years.

The below table reconciles the asset for premium tax credits associated with the assessment at December 31, 2017 to those reported at December 31, 2018.

a.) Assets recognized from paid and accrued premium tax offsets and policy surcharges prior year-end	$	16,748,143
b.) Decreases current year:		
Credits Used		1,573,294
Misc. Adjustments		960,901
c.) Increases current year:		-
d.) Assets recognized from paid and accrued premium tax offsets and policy surcharges current year-end	$	14,213,948

Discount rate applied: 3.50%

The Undiscounted and Discounted Amount of the Guaranty Fund assessments and Related Assets by Insolvency:

Name of the Insolvency	Guaranty Fund Assessment		Related Assets	
	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty	$ 52,772,708	$ 37,040,718	$ 28,063,537	$ 14,213,948

Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency:

	Payables			Recoverables		
Name of the Insolvency	Number of Jurisdictions	Range of Years	Weighted Average Number of Years	Number of Jurisdictions	Range of Years	Weighted Average Number of Years
Penn Treaty	50 states	1 to 70 years	11.96 years	39 states	1 to 20 years	8.1 years

14. Stock-Based Compensation

Humana has plans under which options to purchase Humana common stock and restricted stock units have been granted to executive officers, directors and key employees of the Company. The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards

Humana Insurance Company
Notes to Financial Statements
Statutory Basis of Accounting
December 31, 2018 and 2017

vest upon time-based conditions. In accordance with SSAP No. 104, *Share Based Payments*, stock option plans are recognized as compensatory. As disclosed in Note 10, stock compensation is allocated through management fee agreements from Humana.

At December 31, 2017, the Company's officers, directors and employees held 139,260 options with an average exercise price of $165.54 per share. The Company's officers, directors and employees held 559,026 shares of restricted stock at December 31, 2017.

15. Uninsured Plans

Information for the year ended December 31, 2018 regarding the profitability of ASO plans and the uninsured portion of partially insured plans for which the Company provides administrative services were as follows:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	$ 12,566,063	$ (3,939,871)	$ 8,626,192
Total net other income or expenses (including interest paid to or received from plans)	(426,656)	-	(426,656)
Net gain (loss) from operations	$ 12,139,407	$ (3,939,871)	$ 8,199,536
Total claim payment volume	323,023,026	463,410,759	786,433,785

As of December 31, 2018, the Company has recorded a receivable from CMS of $132,885,205 related to the cost share and reinsurance components of administered Medicare products and a receivable from ASO customers of $18,500,968. The Company has recorded receivables from the following payors whose account balance are greater than 10% of the Company's accounts receivable from uninsured accident and health plans or $10,000:

	2018
Advocate Health Care APP	$ 2,273,917
Maricopa Community College	967,906
DST Systems Inc.	919,670

	2017
Advocate Health Care APP	$ 2,547,433
Greystar Management Service	1,341,517

Supplemental Investment Information

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

Of the **Humana Insurance Company**
Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436
NAIC Group Code 0119 NAIC Company Code 73288 Employer's ID Number 39-1263473

The Investment risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 3 of the statement of admitted assets, liabilities and surplus. $7,233,381,293.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	MET TRANSPRTN AUTH NY REVENUE	BONDS	$ 58,580,371	0.81%
2.02	CD COMMERCIAL MORTGAGE TRUST	BONDS	58,306,521	0.81%
2.03	JPMORGAN CHASE & CO	BONDS	53,406,348	0.74%
2.04	APPLE INC	BONDS	47,965,502	0.66%
2.05	JP MORGAN CHASE	BONDS	45,278,744	0.63%
2.06	MARYLAND ST	BONDS	40,559,910	0.56%
2.07	NEW YORK ST DORM AUTH	BONDS	39,915,350	0.55%
2.08	GOLDMAN SACHS GROUP INC	BONDS	39,247,216	0.54%
2.09	NEW YORK ST DORM AUTH SALES	BONDS	38,255,687	0.53%
2.10	BANK OF AMERICA CORP	BONDS	36,831,207	0.51%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 3,392,278,627	46.90%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	351,917,387	4.87%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	131,242,517	1.81%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	4,803,550	0.07%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	-	0.00%	3.12	P/RP-6	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?		Yes [X]	No [ ]
4.02	Total admitted assets held in foreign investments.	$	27,306,379	0.38%
4.03	Foreign-currency-denominated investments.		-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency		-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	-	0.00%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

			1	**2**
	Countries rated NAIC - 1:			
6.01	Country:	$	-	0.00%
6.02	Country:		-	0.00%
	Countries rated NAIC - 2			
6.03	Country:	$	-	0.00%
6.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
6.05	Country:	$	-	0.00%
6.06	Country:		-	0.00%

7. Aggregate unhedged foreign currency exposure:

		1	**2**
	$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	**2**
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1 Issuer	2 NAIC Rating	3		4
10.01	-	-	$	-	0.00%
10.02	-	-		-	0.00%
10.03	-	-		-	0.00%
10.04	-	-		-	0.00%
10.05	-	-		-	0.00%
10.06	-	-		-	0.00%
10.07	-	-		-	0.00%
10.08	-	-		-	0.00%
10.09	-	-		-	0.00%
10.10	-	-		-	0.00%

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]		No [ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.				
11.02	Total admitted assets held in Canadian Investments	$	-		0.00%
11.03	Canadian-currency-denominated investments		-		0.00%
11.04	Canadian-denominated insurance liabilities		-		0.00%
11.05	Unhedged Canadian currency exposure		-		0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ -	0.00%
	Largest 3 investments with contractual sales restrictions		
12.03		-	0.00%
12.04		-	0.00%
12.05		-	0.00%

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

	1	2	3
	Name of Issuer		
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02	-	$ -	0.00%
16.03	-	-	0.00%
16.04	-	-	0.00%
16.05	-	-	0.00%
16.06	-	-	0.00%
16.07	-	-	0.00%
16.08	-	-	0.00%
16.09	-	-	0.00%
16.10	-	-	0.00%
16.11	-	-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description		
	1	2	3
18.02	-	$ -	0.00%
18.03	-	-	0.00%
18.04	-	-	0.00%
18.05	-	-	0.00%
18.06	-	-	0.00%

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:	**2**	**3**
		$ -	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description **1**	**2**	**3**
19.03	-	$ -	0.00%
19.04	-	-	0.00%
19.05	-	-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2018 and 2017

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Insurance Company
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2018

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
	1 Amount	2 Percentage	1 Amount	2 Percentage
1. Bonds				
1.1 U.S. treasury securities	$ 11,251,562	0.21%	$ 11,251,562	0.21%
1.2 U.S. government agency obligations (excluding mortgage-backed securities)				
1.21 Issued by U.S. government agencies	-	0.00%	-	0.00%
1.22 Issued by U.S. government sponsored agencies	-	0.00%	-	0.00%
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	-	0.00%	-	0.00%
1.4 Securities issued by states, territories, and possessions and political subdivisions in the				
1.41 States, territories and possessions and general obligations	376,467,263	7.11%	376,467,263	7.11%
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	18,807,835	0.36%	18,807,835	0.36%
1.43 Revenue and assessment obligations	584,909,551	11.05%	584,909,551	11.05%
1.44 Industrial development and similar obligations	-	0.00%	-	0.00%
1.5 Mortgage-backed securities (includes residential and commercial MBS)				
1.51 Pass-through securities				
1.511 Issued or guaranteed by GNMA	33,969,419	0.64%	33,969,419	0.64%
1.512 Issued or guaranteed by FNMA and FHLMC	754,876,337	14.26%	754,876,337	14.26%
1.513 All other	-	0.00%	-	0.00%
1.52 CMOs and REMICs				
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	88,885,066	1.68%	88,885,066	1.68%
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	-	0.00%	-	0.00%
1.523 All others	598,586,510	11.31%	598,586,510	11.31%
2. Other debt and other fixed income securities (excluding short-term)				
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	1,079,462,595	20.39%	1,079,462,595	20.39%
2.2 Unaffiliated non-U.S. securities (including Canada)	-	0.00%	-	0.00%
2.3 Affiliated securities	-	0.00%	-	0.00%
3. Equity interests				
3.1 Investments in mutual funds	-	0.00%	-	0.00%
3.2 Preferred stocks				
3.21 Affiliated	-	0.00%	-	0.00%
3.22 Unaffiliated	-	0.00%	-	0.00%
3.3 Publicly traded equity securities (excluding preferred stock)				
3.31 Affiliated	-	0.00%	-	0.00%
3.32 Unaffiliated	-	0.00%	-	0.00%
3.4 Other equity securities				
3.41 Affiliated	804,849,178	15.20%	804,849,178	15.20%
3.42 Unaffiliated	-	0.00%	-	0.00%
3.5 Other equity interests including tangible personal property under lease				
3.51 Affiliated	-	0.00%	-	0.00%
3.52 Unaffiliated	-	0.00%	-	0.00%
4. Mortgage loans				
4.1 Construction and land development	-	0.00%	-	0.00%
4.2 Agricultural	-	0.00%	-	0.00%
4.3 Single family residential properties	-	0.00%	-	0.00%
4.4 Multifamily residential properties	-	0.00%	-	0.00%
4.5 Commercial loans	8,550,000	0.16%	8,550,000	0.16%
4.6 Mezzanine real estate loans	-	0.00%	-	0.00%
5. Real estate investments				
5.1 Property occupied by the company	13,576,713	0.26%	13,576,713	0.26%
5.2 Property held for the production of income (including $ of property acquired in the satisfaction of debt)	-	0.00%	-	0.00%
5.3 Property held for sale (including $ of property acquired in the satisfaction of debt)	-	0.00%	-	0.00%
6. Contract loans	-	0.00%	-	0.00%
7. Derivatives	-	0.00%	-	0.00%
8. Receivables for securities	-	0.00%	-	0.00%
9. Securities Lending	-	0.00%	-	0.00%
10. Cash, cash equivalents and short-term investments	919,317,771	17.37%	919,317,771	17.37%
11. Other invested assets	-	0.00%	-	0.00%
12. Total invested assets	$ 5,293,509,800	100.00%	$ 5,293,509,800	100.00%

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2020

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 or other jurisdiction of incorporation of organization)	(I.R.S. Employer Identification No.)

500 West Main Street, Louisville, Kentucky 40202
(Address of principal executive offices, and 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	Trading Symbol	Name of exchange on which registered
Common stock, $0.16 2/3 par value	**HUM**	**New York Stock Exchange**

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

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

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

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

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

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☑

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

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2020 was $50,711,683,757 calculated using the average price on June 30, 2020 of $384.15 per share.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2021 was 128,861,929.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Definitive Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 22, 2021. Such Definitive Proxy Statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

HUMANA INC.
INDEX TO ANNUAL REPORT ON FORM 10-K
For the Year Ended December 31, 2020

		Page
	Part I	
Item 1.	Business	4
Item 1A.	Risk Factors	22
Item 1B.	Unresolved Staff Comments	37
Item 2.	Properties	37
Item 3.	Legal Proceedings	37
Item 4.	Mine Safety Disclosures	37
	Part II	
Item 5.	Market for the Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	38
Item 6.	Selected Financial Data	41
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	42
Item 7A.	Quantitative and Qualitative Disclosures about Market Risk	67
Item 8.	Financial Statements and Supplementary Data	69
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	124
Item 9A.	Controls and Procedures	124
Item 9B.	Other Information	125
	Part III	
Item 10.	Directors, Executive Officers and Corporate Governance	126
Item 11.	Executive Compensation	127
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	127
Item 13.	Certain Relationships and Related Transactions, and Director Independence	128
Item 14.	Principal Accounting Fees and Services	128
	Part IV	
Item 15.	Exhibits, Financial Statement Schedules	129
Item 16.	Form 10-K Summary	142
	Signatures and Certifications	143

Forward-Looking Statements

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

PART I

ITEM 1. BUSINESS

General

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

As of December 31, 2020, we had approximately 17 million members in our medical benefit plans, as well as approximately 5 million members in our specialty products. During 2020, 83% 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 728,300 members as of December 31, 2020.

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 2020 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2020 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Business Segments

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable 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, the Chief Operating Decision Maker, to assess performance and allocate resources. See Note 18 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

Our Products

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

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2020:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 51,697	68.0 %
Group Medicare Advantage	7,774	10.2 %
Medicare stand-alone PDP	2,742	3.6 %
Total Retail Medicare	62,213	81.8 %
State-based Medicaid	4,223	5.6 %
Medicare Supplement	688	0.9 %
Total premiums	67,124	88.3 %
Services	19	— %
Total premiums and services revenue	$ 67,143	88.3 %

Medicare

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

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

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, Private Fee-For-Service, or PFFS, and Special Needs Plans, including Dual Eligible Special Needs, or D-SNP, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data

analysis techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

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

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

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. For more information refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data and Item 1A. - Risk Factors.

At December 31, 2020, we provided health insurance coverage under CMS contracts to approximately 3,962,700 individual Medicare Advantage members, including approximately 728,300 members in Florida. These Florida contracts accounted for premiums revenue of approximately $10.9 billion, which represented approximately 21.1% of our individual Medicare Advantage premiums revenue, or 14.4% of our consolidated premiums and services revenue for the year ended December 31, 2020.

Our individual Medicare Advantage 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 2021, and all of our product offerings filed with CMS for 2021 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, titled "Medicare Part D." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2021, and all of our product offerings filed with CMS for 2021 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 are primarily offered as PPO plans on the same Medicare platform as individual Medicare Advantage plans. These plans offer the same types of benefits and services available to members in our individual Medicare plans discussed previously, however, group Medicare Advantage plans typically have richer benefit offerings than individual Medicare Advantage plans, including prescription drug coverage in the gap, for instance, due to the desire of many customers to closely match their pre-retirement benefit structure.

Medicare Supplement

We also offer Medicare supplement products that helps pay the medical expenses that Medicare FFS does not cover, such as copayments, coinsurance and deductibles.

State-based Medicaid Contracts

Through our state-based contracts, we serve members enrolled in Medicaid, a program funded by both the federal and state governments and administered by states to care for their most vulnerable populations. Within federal guidelines, states determine whom to cover, but general categories for traditional Medicaid programs include: children and some adults receiving assistance through Temporary Assistance to Needy Families, or TANF, and Aged, Blind, and Disabled, or ABD, adults. Through the Long-Term Support Services, or LTSS, program, states offer programs to deliver support services to people who receive home and community or institution-based services for long-term care.

We have contracts in several states to serve Medicaid-eligible members. In Florida, we cover the traditional programs (TANF and ABD members), as well as provide LTSS services. In Kentucky, we serve the traditional programs. Originally, our Kentucky Medicaid contract was subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource; however, effective January 1, 2020, we terminated the reinsurance agreement with CareSource and assumed full administration and financial risk. In 2021, our Medicaid business significantly expanded in several states, including in Wisconsin with the acquisition of iCare on

January 1, 2021, in Oklahoma with a new contract award; and in South Carolina with the approval to participate in its traditional managed Medicaid program.

We also serve members who qualify for both Medicaid and Medicare, referred to as "dual eligible," through our Medicaid, Medicare Advantage, and stand-alone prescription drug plans. As the dual eligible population represents a disproportionate share of costs, Humana is participating in varied integration models designed to improve health outcomes and reduce avoidable costs. These programs largely operate separately from traditional Medicaid and LTSS programs. We currently serve dual eligible members under CMS's dual eligible demonstration program in Illinois, and have been approved to participate in South Carolina's dual demonstration program starting in January 2022.

As part of our individual Medicare Advantage products, we also offer D-SNP plans. In connection with offering a D-SNP plan in a particular state, we are required to enter into a special coordinating contract with the applicable state Medicaid agency. To meet federal requirements that took effect in 2021, states have begun to implement new D-SNP requirements to strengthen Medicaid-Medicare integration requirements for D-SNPs. Some states are also moving to support the dual eligible population by linking D-SNP participation to enrollment in a plan that also participates in a state-based Medicaid program to coordinate and integrate both Medicare and Medicaid benefits.

Our Group and Specialty Segment Products

The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision and life insurance benefits, as well as administrative services only, or ASO products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group and Specialty segment by product for the year ended December 31, 2020:

	Group and Specialty Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 4,761	6.3 %
Specialty	1,699	2.2 %
Total premiums	6,460	8.5 %
Services	780	1.0 %
Total premiums and services revenue	$ 7,240	9.5 %
Intersegment services revenue	$ 29	n/a

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts.

Our ASO products are offered to small group and large group 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 the costs of health benefits, with large group customers retaining a greater share

and small group customers a smaller share of the cost of health benefits. All small group ASO customers and many large group ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

Employers can customize their offerings with optional benefits such as dental, vision, and life products. We also offer optional benefits such as dental and vision to individuals.

Military Services

Under our TRICARE contracts with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. Under our contracts, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. On January 1, 2018, we began to deliver services under the T2017 East Region contract. The T2017 East Region contract comprises 32 states and approximately six million TRICARE beneficiaries. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, clinical care services, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 18 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, 2020:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 24,587	n/a
Provider services	2,266	n/a
Clinical care services	566	n/a
Total intersegment revenue	$ 27,419	
External services revenue:		
Pharmacy solutions	$ 581	0.8 %
Provider services	328	0.4 %
Clinical care services	107	0.1 %
Total external services revenue	$ 1,016	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.

Provider services

We operate full-service, multi-specialty medical centers in a number of states, including Florida, Kansas, Louisiana, Missouri, Nevada, North Carolina, South Carolina, and Texas, staffed by primary care providers and medical specialists with a primary focus on the senior population under our Care Delivery Organization, or CDO. CDO operates these clinics primarily under the Conviva, Partners in Primary Care or Family Physicians Group, or FPG, brands. Our care delivery subsidiaries operate our medical center business through both employed physicians and care providers, and through third party management service organizations with whom we contract to arrange for and manage certain clinical services. CDO currently operates 156 medical centers and employs or contracts with 662 primary care providers, serving approximately 255,400 members, generally under risk sharing arrangements with Humana and third party health plans.

CDO also operates a Medical Services Organization, or MSO, through Conviva that coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. This MSO 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. Conviva's MSO 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.

In February 2020, Partners in Primary Care entered into a strategic partnership with Welsh, Carson, Anderson & Stowe to open a minimum of 50 additional payor-agnostic, senior-focused primary care centers over the next three years and in 2018 we acquired FPG serving Medicare Advantage and Managed Medicaid HMO patients through its senior focused clinics in Greater Orlando, Florida. Also, during 2018, we acquired the remaining equity interest in Miami, Florida based MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Clinical care services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Clinical care services include the operations of Humana At Home, Inc., or Humana At Home®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. At December 31, 2020, we have enrolled approximately 910,600 members, with complex chronic conditions participating in a Humana Chronic Care Program, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. These members may not be unique to each program since members have the ability to enroll in multiple programs. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

We have committed additional investments in our home care capabilities with our acquisition of a 40% minority interest in Kindred at Home, Inc., or Kindred at Home, and Curo Health Services, or Curo, which combined creates the nation's largest home health and hospice provider with significant overlap with our individual Medicare Advantage business. See Note 4 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management and wellness programs. These programs use our capabilities that enable us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions

of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

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

Wellness

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

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

Our Individual Commercial Segment Products

Our individual health plans were marketed under the HumanaOne brand. We offered products both on and off of the public exchange.

We discontinued substantially all off-exchange individual commercial medical plans effective January 1, 2017, and we exited our remaining individual commercial medical business effective January 1, 2018.

Other Businesses

Other Businesses includes those businesses that do not align with the reportable segments previously described, primarily our closed-block long-term care insurance policies, which were sold in 2018. For a detailed discussion of the sale refer to Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Membership

The following table summarizes our total medical membership at December 31, 2020, by market and product:

	Retail Segment				Group and Specialty Segment					
	(in thousands)									
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Total	Percent of Total
Florida	728.3	7.5	169.7	18.1	594.4	135.2	40.1	—	1,693.3	10.1 %
Texas	319.7	247.9	266.9	27.4	—	114.0	33.4	—	1,009.3	6.0 %
Kentucky	107.3	69.2	167.0	7.4	168.6	94.6	136.5	—	750.6	4.5 %
Georgia	196.0	1.9	101.8	11.1	—	113.6	77.9	—	502.3	3.0 %
California	95.1	0.9	383.9	20.7	—	—	—	—	500.6	3.0 %
Illinois	139.1	26.1	153.1	8.0	9.4	26.9	39.3	—	401.9	2.4 %
Ohio	164.0	22.1	109.9	40.5	—	26.9	31.1	—	394.5	2.3 %
Missouri/Kansas	105.9	4.7	166.3	14.2	—	35.5	28.6	—	355.2	2.1 %
North Carolina	188.6	0.4	133.6	6.6	—	—	—	—	329.2	2.0 %
Tennessee	152.4	3.7	97.8	8.3	—	36.5	21.2	—	319.9	1.9 %
Louisiana	183.4	13.5	53.7	3.8	—	43.9	20.1	—	318.4	1.9 %
Virginia	134.4	3.9	118.6	9.1	—	—	—	—	266.0	1.6 %
Indiana	120.0	6.7	102.0	11.6	—	17.5	6.9	—	264.7	1.6 %
Wisconsin	61.1	5.6	87.3	7.5	—	51.0	29.4	—	241.9	1.4 %
Michigan	89.9	20.2	102.9	6.1	—	1.4	—	—	220.5	1.3 %
Alabama	75.4	82.5	55.7	5.0	—	—	—	—	218.6	1.3 %
Arizona	99.5	0.4	78.2	9.0	—	19.1	7.9	—	214.1	1.3 %
New York	75.2	6.4	113.0	8.1	—	—	—	—	202.7	1.1 %
Military services	—	—	—	—	—	—	—	5,998.7	5,998.7	35.6 %
Others	927.4	89.6	1,405.3	113.1	—	61.3	32.5	—	2,629.2	15.6 %
Totals	3,962.7	613.2	3,866.7	335.6	772.4	777.4	504.9	5,998.7	16,831.6	100.0 %

Provider Arrangements

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

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

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate for diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge

for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

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

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

Capitation

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

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

At December 31, 2020, approximately 1,465,700 members, or 8.7% of our medical membership, were covered under risk-based contracts, which provide all member benefits, including 1,231,900 individual Medicare Advantage members, or 31.1% 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 measure the financial performance of our capitated providers and require guarantees in certain instances. However, we delegated claim processing functions under capitation arrangements covering approximately 230,400 HMO members, including 224,300 individual Medicare Advantage members, or 18.2% of the 1,231,900 individual Medicare Advantage members covered under risk-based contracts at December 31, 2020, 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 $2.4 billion, or 3.9% of total benefits expense, for the year ended December 31, 2020. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

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

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

Recredentialing of participating providers occurs every three years, unless otherwise required by state or federal regulations. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee composed of a peer group of providers reviews the applications of providers being considered for credentialing and recredentialing.

We maintain accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), and/or URAC. Certain commercial businesses, such as those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, population health management, credentialing, utilization management, network management, and member experience. We have achieved and maintained NCQA accreditation in many of our commercial, Medicare and Medicaid HMO/POS and PPO markets and our wellness program, Go365. Humana's pharmacy organization is accredited by URAC.

Sales and Marketing

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

At December 31, 2020, we employed approximately 1,400 sales representatives, as well as approximately 1,600 telemarketing representatives who assisted in the marketing of Medicare products, including Medicare Advantage and PDP, in our Retail segment and specialty products in our Group and Specialty segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare Stand-Alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group and Specialty segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. We use licensed independent brokers, independent agents, digital insurance agencies, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our specialty products.

Underwriting

Since 2014, the Patient Protection and Affordability Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Health Care Reform Law, requires certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our individual Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2020 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system, including the Health Care Reform Law.

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

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2020 Form 10-K.

Certain Other Services

Captive Insurance Company

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

Centralized Management Services

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

Human Capital Management

Our associates are essential to our success in delivering on our core strategy, and creating positive healthcare experiences for our members. We are committed to recruiting, developing, and retaining strong, diverse teams, actively promoting a culture of inclusion and diversity. As of December 31, 2020, we had approximately 48,700 associates and approximately 900 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations.

Our Culture

We believe that our members' experience is linked to our associates' experience and that engaged, productive associates are the key to building a healthy company, creating a caring environment that enables our associates to go above and beyond for our members, driving innovation, and allowing for fulfilling experiences that incentivize them to stay with us over the long-term. Each year, we measure our success and opportunities to advance through our annual, third-party administered Associate Experience Survey. Results of the 2020 survey showed that 93% of associates are highly engaged. To continue to build on these results, we provide the survey results to our entire associate population and encourage leaders to use the information to create open, honest action plans with their teams to further deepen our collective engagement.

Inclusion and Diversity

Our associates' vast experiences and perceptions, their unique characteristics, backgrounds and beliefs, drive the groundbreaking, strategic thinking that gives our Company its competitive edge. We are committed to having balanced diversity at all levels of the Company and have developed a pathway for top, diverse talent within our recruiting initiatives. To achieve our recruiting and hiring goals we partner with local and national advocacy groups to provide information about open roles, assistance with resume preparation and application submission.

We have also incorporated balanced interview panels into our interview process, through which we strategically engage a broad spectrum of interviewers that bring greater diversity and perspective. This proven best practice strengthens the candidate experience and hiring of diverse talent, ensuring we get the right talent for any given role, and minimizes the potential for personal blind spots when evaluating candidates.

Pay and Benefits Philosophy, Compensation and Financial Security

Our Company's pay and benefits structure is designed to motivate and reward our associates at all levels of the organization for their skill development, demonstration of our values and performance. While our programs vary by location and business, they may include:

Financial	**Health**	**Life**
Competitive Base Pay	Medical, Dental and Vision Benefits	Paid time off, paid holidays and jury duty pay
Associate Incentive Plan (Annual Bonus)	Supplemental Health Benefits	Paid Parental Leave
Supplemental Pay (Including Overtime)	Long-term Care Insurance	Caregiver Time Off Program
Recognition Pay and Service Awards	Wellness and Rewards Program	Employee Assistance Program
401(k) Retirement Savings Plan with Company Match Program	Health Plan Incentives	Associate Discount Programs and Services
Life insurance	On-site Health and Fitness Centers	Helping Hands Program
Short- and Long-Term Disability Insurance	On-site Health Screenings and Vaccinations	Transit Services

Talent Development and Growth Opportunities

We champion the individual goals and development of our associates, and provide a number of programs to ensure that our associates have the resources and support they need to deliver on their passion. We provide opportunities for our associates to earn professional certifications through continued education programs and to participate in instructor-led and online courses designed to strengthen soft and hard-skills and enhance leadership development. Our Career Cultivation team sponsors workshops and events to promote associate accountability within their personal and professional growth as part of overall career development. Our associates are also encouraged to participate in mentoring programs with people of various backgrounds and cultures. We view mentoring as an essential development tool for sharing skills and knowledge so we can all succeed. Our commitment to mentoring feeds the successful future of our Company. Additionally, we utilize development programs to enhance talent within our organizations through targeted internal initiatives, where we aim to upskill and reskill existing associates for opportunities in new career pathways.

COVID-19

Our response to the pandemic and performance throughout 2020 would not have been possible without the extraordinary, resilient efforts of our associates, who went above and beyond to continually meet the needs of our stakeholders while facing their own daily challenges as a result of COVID-19. To support them, we quickly transitioned nearly all of our workforce to a remote work environment, while ensuring that our frontline care providers, clinicians, and pharmacists who continued to care for our members and patients in our clinics and in the home, and ensure that they had access to their medications, had the equipment and space to safely do so. We also expanded our benefits to assist our associates who faced financial hardship and to address the difficulties that the pandemic presented to daily life. A few of those COVID-19 response initiatives are highlighted below.

- transitioning approximately 94% of the workforce to work-at-home and equipping them with the necessary technology and resources for a successful remote work environment.
- providing funding for emergency relief for elder and child caregiving and financial hardship from family job loss, food insecurity and household essentials.
- adjusting pay and leave policies to provide additional paid time off to manage personal challenges as a result of COVID-19 including school closings and child care.

Additional information related to our human capital can be found by referencing our Definitive Proxy Statement of the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the captions "Human Capital Management" and "Our COVID-19 Response."

Information About Our Executive Officers

Set forth below are names and ages of all of our current executive officers as of February 1, 2021, their positions, and the date first elected as an officer:

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	58	President and Chief Executive Officer, Director	12/11	(1)
Vishal Agrawal, M.D.	46	Chief Strategy and Corporate Development Officer	12/18	(2)
Heather M. Carroll Cox	50	Chief Digital Health and Analytics Officer	08/18	(3)
Sam M. Deshpande	56	Chief Technology and Risk Officer	07/17	(4)
Susan M. Diamond	47	Segment President, Home Business	07/19	(5)
William K. Fleming, PharmD	53	Segment President, Clinical and Pharmacy Solutions	03/17	(6)
Christopher H. Hunter	52	Segment President, Group and Military Business	01/14	(7)
Timothy S. Huval	54	Chief Administrative Officer	12/12	(8)
Brian A. Kane	48	Chief Financial Officer	06/14	(9)
William H. Shrank, M.D., MSHS	49	Chief Medical and Corporate Affairs Officer	04/19	(10)
Joseph C. Ventura	44	Chief Legal Officer	02/19	(11)
T. Alan Wheatley	53	Segment President, Retail	03/17	(12)
Cynthia H. Zipperle	58	Senior Vice President, Chief Accounting Officer and Controller	12/14	(13)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Dr. Agrawal currently serves as Chief Strategy and Corporate Development Officer, having joined the company in December 2018. Prior to joining the company, Dr. Agrawal was Senior Advisor for The Carlyle Group L.P., having held that position from October 2017 to December 2018. Previously, Dr. Agrawal was President and Chief Growth Officer of Ciox Health, the largest health information exchange and release of information services organization in the U.S. from December of 2015 to October 2018. Prior to joining Ciox Health, Dr. Agrawal served as President of Harris Healthcare Solutions from January 2013 to December 2015.

(3) Ms. Cox currently serves as Chief Digital Health and Analytics Officer, having joined the Company in August 2018. Prior to joining the Company, Ms. Cox served as Chief Technology and Digital Officer at USAA, where she led the teams responsible for designing and building personalized and digitally-enabled end-to-end experiences for USAA members. Prior to USAA, Heather was the CEO of Citi FinTech at Citigroup, Inc., helping the company adapt to a future dominated by mobile technology, and she headed Card Operations, reshaping customer and digital experience for Capital One.

(4) Mr. Deshpande currently serves as Chief Technology and Risk Officer, having been elected to this position in August 2019, from his prior role as Chief Risk Officer. Before joining Humana in July 2017, Mr. Deshpande spent 17 years at Capital One in key leadership positions, most recently as Business Chief Risk Officer for the U.S. and international card business. He previously served as the Business Chief Risk Officer and Head of Enterprise Services for the Financial Services Division, responsible for Business Risk, Data Science, Data Quality, Process Excellence and Project Management. He also led marketing and analysis for the Home Loans, Auto Finance, and Credit Card businesses, with responsibilities for business strategy, credit, product and marketing.

(5) Ms. Diamond currently serves as Segment President, Home Business, having been elected to this position in July 2019. Ms. Diamond joined the Company in June 2004 and has spent the majority of her Humana career in various leadership roles in the Medicare business, with a particular passion and emphasis on growth and consumer segmentation strategies for the Company's individual Medicare Advantage and Stand Alone Part D offerings. Ms. Diamond also served for two and a half years as the Enterprise Vice President of Finance, where she was responsible for enterprise planning and forecasting, trend analytics and had responsibility for each of the Company's line of business CFOs and controllers.

(6) Dr. Fleming currently serves as Segment President, Clinical and Pharmacy Solutions, where he is responsible for Humana's Clinical Solutions (strategy, quality, trend, and operations), Pharmacy Solutions (PBM, mail, specialty, retail), and Enterprise Clinical Operating Model, having held this position since December 2019. Prior to that, Dr. Fleming held positions of Segment President, Healthcare Services as well as President of the Company's pharmacy business. Dr. Fleming joined the Company in 1994.

(7) Mr. Hunter currently serves as Segment President, Group and Military Business, having been elected to this position in August 2018 after having previously served as the Company's Chief Strategy Officer since January 2014. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(8) Mr. Huval currently serves as Chief Administrative Officer, having been elected to this position in July 2019, from his previous role as Chief Human Resources Officer. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(9) Mr. Kane currently serves as Chief Financial Officer, having been elected to this position in June 2014. He also oversees the operations of Humana's primary care business. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(10) Dr. Shrank currently serves as Chief Medical and Corporate Affairs Officer, having been elected to this position in July 2019, from his previous role as Chief Medical Officer. Before joining Humana in April 2019, Dr. Shrank served as Chief Medical Officer, Insurance Services Division at the University of Pittsburgh Medical Center, from 2016-2019, where he oversaw approximately $9 billion in annual health care expenditures for approximately 3.5 million members in Medicare, Medicaid, behavioral health, Managed Long Term Social Supports and commercial lines of business. He also developed and evaluated population health programs to further advance the medical center's mission as an integrated delivery and financing system. Prior to that, Dr. Shrank served as Senior Vice President, Chief Scientific Officer, and Chief Medical Officer of Provider Innovation at CVS Health from 2013 to 2016. Prior to joining CVS Health, Dr. Shrank served as Director, Research and Rapid-Cycle Evaluation Group, for the Center for Medicare and Medicaid Innovation, part of CMS from 2011 to 2013, where he led the evaluation of all

payment and health system delivery reform programs and developed the rapid-cycle strategy to promote continuous quality improvement. Dr. Shrank began his career as a practicing physician with Brigham and Women's Hospital in Boston and as an Assistant Professor at Harvard Medical School. His research at Harvard focused on improving the quality of prescribing and the use of chronic medications. He has published more than 200 papers on these topics.

(11) Mr. Ventura currently serves as Chief Legal Officer. He joined the Company in January 2009 and since then has held various positions of increasing responsibility in the Company's Law Department, including most recently, Senior Vice President, Associate General Counsel & Corporate Secretary from July 2017 until February 2019.

(12) Mr. Wheatley currently serves as Segment President, Retail, having held this position since March 2017. During his long-tenured career with the Company, Mr. Wheatley has served in a number of key leadership roles, including Vice President of Medicare Service Operations and President of the East Region, one of the Company's key Medicare geographies.

(13) Ms. Zipperle currently serves as Senior Vice President, Chief Accounting Officer and Controller, having held this position since December 2014. Ms. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

ITEM 1A. RISK FACTORS

Risks Relating to Our Business

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. 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. Accordingly, our reserves may be insufficient.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members, including claims payments, capitation payments to providers (predetermined amounts paid to cover services), estimates of future payments to hospitals and others for medical care provided to our members, and various other costs. 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, prescription drugs, or 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 purchase discounts or pharmacy volume rebates received from drug manufacturers and wholesalers, which are generally passed on to clients in the form of steeper price discounts;
- catastrophes, including acts of terrorism, public health emergencies, epidemics or pandemics (such as the spread of the novel coronavirus (COVID-19) or severe weather (e.g. hurricanes and earthquakes));
- medical cost inflation; and
- government mandated benefits, member eligibility criteria, or other legislative, judicial, or regulatory changes.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part

on our ability to appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

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

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

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors through the Medicare Annual Enrollment Period. In addition, contracts for the sale of group 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 and administrative costs.

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

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

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

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

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

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. The growth of our Medicare products is an important part of our business strategy, and the attendant concentration of revenues intensifies the risks to us inherent in Medicare products. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows.

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

If we fail to properly maintain the integrity of our data, to strategically maintain existing or 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. These 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 difficulty preventing and detecting fraud, 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 and service providers, 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. The misappropriation of our proprietary information and/or third-party infringement claims against any software products we use could hinder our ability to market and sell products and services and may result in a material adverse effect on our results of operations, financial position and cash flows.

There can be no assurance that our information technology, or IT, process will successfully maintain and improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, or improve service levels. Failure to adequately protect and maintain the integrity of our information systems and data 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, and rely on third party service providers to do the same, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. We have been, and will likely continue to be, regular targets of attempted cybersecurity attacks and other security threats and may be subject to breaches of our information technology security systems. Although the impact of such attacks has not been material to our operations or results of operations, financial position, or cash flow through December 31, 2020, we can provide no assurance that we will be able to detect, prevent, or contain the effects of such cybersecurity attacks or other information security risks or threats in the future. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems, or the security of third party service providers, 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 detect, prevent, 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 or the security measures of third party service providers, and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our associates' or members' private information and result in the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

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

We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment compensation and other labor and employment practice suits, employee benefit claims, stockholder suits and other securities laws claims, intellectual and other property 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 brought against our employed providers or affiliated physician-owned professional groups, based on our medical necessity decisions or brought against us on the theory that we are liable for a third-party providers' alleged malpractice; claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients; allegations of anti-competitive and unfair business activities; provider disputes over compensation or non-acceptance or termination of provider contracts; disputes related to ASO business, including actions alleging claim administration errors; qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model; claims related to the failure to disclose some business practices; claims relating to customer audits and contract performance; claims relating to dispensing of drugs associated with our in-house dispensing pharmacies; 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 17 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 88% of our total premiums and services revenue for the year ended December 31, 2020. These programs involve various risks, as described further below.

- At December 31, 2020, under our contracts with CMS we provided health insurance coverage to approximately 728,300 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, 2020. The loss of these and other CMS contracts (which are generally renewed annually) 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 or changes to member eligibility criteria 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, 2020, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2020, primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising 32 states and approximately six million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5 -year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option. The loss of the TRICARE T2017 East Region contract may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If

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

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

  CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

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

  In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of the government's traditional fee-for-service Medicare program, or Medicare FFS. We refer to the process of accounting for errors in FFS claims as the "FFS Adjuster." This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern

differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

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

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We believe that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and have provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial position, or cash flows.

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

We believe that CMS's statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS's 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS's final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

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

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net asset of $95 million at December 31, 2020 and net payable of $170 million at December 31, 2019.

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

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

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

Our business activities are subject to substantial government regulation. New laws or regulations, or legislative, judicial, or regulatory changes in existing laws or regulations or their manner of application could increase our cost of doing business and 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 by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Health Care Reform Law and Other Current or Future Legislative, Judicial or Regulatory Changes

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. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases our effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative (including the Families First Coronavirus Response Act (the "Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and other legislative or regulatory action taken in response to COVID-19), judicial or regulatory changes, including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage business profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, or increases in regulation of our prescription drug benefit businesses, 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 assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the Health Care Reform Law or declare all or certain portions of the Health Care Reform Law unconstitutional, create uncertainty for our business, and we cannot predict when, or in what form, such legislative changes or judicial determinations may occur.

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 the confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent. These regulations set

standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures.

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened and strengthened the scope of the privacy and security regulations of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other requirements, the HITECH Act and HIPAA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI, 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. 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).

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

We are subject to various federal and state healthcare fraud and abuse laws including the federal False Claims Act (the “False Claims Act”), the federal anti-kickback statute (the “Anti-Kickback Statute”), the federal “Stark Law,” and related state laws. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participating in the Medicare and Medicaid programs or other government healthcare programs. The False Claims Act prohibits knowingly submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. 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 business under Medicare or other governmental health program. The Stark Law prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services to any entity with which the physician, or an immediate family member of the physician, has a financial relationship, unless the financial relationship fits within a permissible exception.

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.

In November 2020, the Office of the Inspector General of the Department of Health and Humana Services issued a final rule to eliminate, under the Anti-Kickback Statute's regulatory discount safe harbor, protection for rebates paid by manufacturers to Part D plan sponsors or their PBMs in connection with the sale or purchase of Part D drugs. This regulatory change is currently scheduled to become effective on January 1, 2023. The final rule also introduced a new safe harbor to protect reductions in price from manufacturers on prescription drugs that are payable under Medicare Part D or by Medicaid managed care organizations when such price reduction is offered at the point of sale. The precise interpretation, impact, and legality of the final rule are not clear and are subject to pending litigation.

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.

State Regulation of Insurance-Related Products

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

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

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

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions, investments, joint ventures or strategic alliances may cause asset write-offs, restructuring costs or other expenses and may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic,

growth or profitability objectives, and we may divest or wind down such businesses. There can be no assurance that we will be able to complete any such divestiture on terms favorable to us, and 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.

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.

The success of our care delivery businesses depends on our ability, and the ability of our affiliated physician-owned professional groups and management services organizations, to recruit, hire, acquire, contract with, and retain physicians and other medical professionals who are experienced in providing care services to older adults. The market to acquire or manage physician practices, and to employ or contract with individual physicians is, and is expected to remain, highly competitive, and the performance of our care delivery businesses may be adversely impacted if we, and our affiliated physician-owned professional groups and management services organizations, are unable to attract, maintain satisfactory relationships with, and retain physicians and other medical professionals, or if these businesses are unable to retain patients following the departure of a physician. In addition, our care delivery businesses contract with competitors of our health benefits businesses, and these businesses could suffer if they are unable to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

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

Our in-house dispensing pharmacy business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies.

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

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, including manufacturing, distribution or other supply chain disruptions that could impact the availability or cost of supplying of such 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 in-house dispensing 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.

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. 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. 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.

We believe that certain of our customers place importance on our claims paying ability, financial strength, and debt ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings impact our ability to obtain future borrowings and 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.

Ongoing 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 or are not required to sell a security in an unrealized loss position, potential credit related impairments are considered using a variety of factors, including the 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 credit related 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, including the heightened uncertainty created by the COVID-19 pandemic, 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.

The spread of, and response to, COVID-19 underscores certain risks we face, including those discussed above, and the ongoing, heightened uncertainty created by the pandemic precludes any prediction as to the ultimate adverse impact to us of COVID-19.

COVID-19, which has spread to every state in the United States and been declared a pandemic by the World Health Organization, underscores certain risks we face, including those discussed above. To the extent that the spread of COVID-19 is not contained, the premiums we charge may prove to be insufficient to cover the cost of health care services delivered to our members, which may increase significantly as a result of higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs. We may also experience increased costs or decreased revenues if, as a result of our members being unable or unwilling to see their providers due to actions taken to mitigate the spread of COVID-19, we are unable to implement clinical initiatives to manage health care costs and chronic conditions of our members, and appropriately document their risk profiles. In addition, we are offering, and have been mandated by legislative and regulatory action (including the Families First Act and CARES Act) to provide, certain expanded benefit coverage to our members, such as waiving out of pocket costs for COVID-19 testing and treatment. We are also taking actions designed to help provide financial and administrative relief for the health care provider community. Such measures and any further steps taken by us, or governmental action, to continue to respond to and to address the ongoing impact of COVID-19 (including further expansion or modification of the services delivered to our members, the adoption or modification of regulatory requirements associated with those services and the costs and challenges associated with ensuring timely compliance with such requirements) to provide further relief for the health care provider community, or in connection with the relaxation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity, including the potential for widespread testing and therapeutic treatments and the distribution and administration of COVID-19 vaccines, could adversely impact our profitability.

The spread and impact of COVID-19, or actions taken to mitigate this spread, could have material and adverse effects on our ability to operate effectively, including as a result of the complete or partial closure of facilities or labor shortages. Disruptions in public and private infrastructure, including communications, availability of in-person sales and marketing channels, financial services and supply chains, could materially and adversely disrupt our normal business operations. We have transitioned a significant subset of our employee population to a remote work environment in an effort to mitigate the spread of COVID-19, as have a number of our third-party service providers, which may exacerbate certain risks to our business, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, and increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties. The outbreak of COVID-19 has severely impacted global economic activity, including the businesses of some of our commercial customers, and caused significant volatility and negative pressure in the financial markets. In addition to disrupting our operations, these developments may adversely affect the timing of commercial customer premium collections and corresponding claim payments, the value of our investment portfolio, or future liquidity needs.

The ongoing, heightened uncertainty created by the pandemic precludes any prediction as to the ultimate adverse impact to us of COVID-19. We are continuing to monitor the spread of COVID-19, changes to our benefit coverages, and the ongoing costs and business impacts of dealing with COVID-19, including the potential costs and impacts associated with lifting, or reimposing, restrictions on movement and economic activity, the timing and degree in resumption of demand for deferred healthcare services, the pace of administration of COVID-19 vaccines and the effectiveness of those vaccines, and related risks. The magnitude and duration of the pandemic and its ultimate impact on our business, results of operations, financial position, and cash flows is uncertain, but such impacts could be material to our business, results of operations, financial position and cash flows.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

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.

We owned or leased numerous medical centers and administrative offices at December 31, 2020. The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of these medical centers, approximately 195 of these facilities are leased or subleased to our contracted providers to operate.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, qui tam litigation brought by individuals seeking to sue on behalf of the government, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings and Certain Regulatory Matters" in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM.

Holders of our Capital Stock

As of January 31, 2021, there were 1,943 holders of record of our common stock and 297,870 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2019 and 2020, under our Board approved quarterly cash dividend policy:

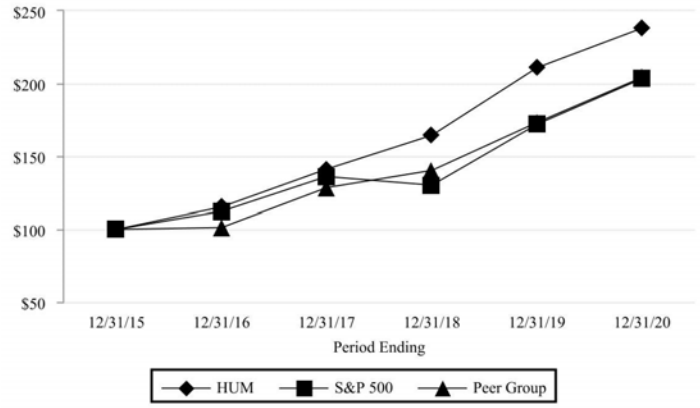
Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2019 payments			
12/31/2018	1/25/2019	$0.500	$68
3/29/2019	4/26/2019	$0.550	$74
6/28/2019	7/26/2019	$0.550	$74
9/30/2019	10/25/2019	$0.550	$73
2020 payments			
12/31/2019	1/31/2020	$0.550	$73
3/31/2020	4/24/2020	$0.625	$83
6/30/2020	7/31/2020	$0.625	$83
9/30/2020	10/30/2020	$0.625	$83

On November 1, 2020, the Board declared a cash dividend of $0.625 per share that was paid on January 29, 2021 to stockholders of record on December 31, 2020, for an aggregate amount of $81 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2021, the Board declared a cash dividend of $0.70 per share payable on April 30, 2021 to stockholders of record on March 31, 2021.

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, 2020. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2015, and that dividends were reinvested when paid.



	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020
HUM	$ 100	$ 115	$ 141	$ 164	$ 211	$ 238
S&P 500	$ 100	$ 112	$ 136	$ 130	$ 172	$ 203
Peer Group	$ 100	$ 101	$ 128	$ 140	$ 173	$ 204

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, 2020 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1) (2) (3)
October 2020	—	$ —	—	$ 2,000,000,000
November 2020	—	—	—	2,000,000,000
December 2020	3,829,420	388.44	3,829,420	250,000,000
Total	3,829,420	$ 388.44	3,829,420	

(1) On December 22, 2020, we entered into separate accelerated stock repurchase agreements, ("the December 2020 ASR Agreements"), with Citibank, N.A., or Citi, and JPMorgan Chase Bank, or JPM, to repurchase $1.75 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on July 30, 2019. On December 23, 2020, in accordance with the December 2020 ASR Agreements, we made a payment of $1.75 billion ($875 million to Citi and $875 million to JPM) and received an initial delivery of 3.8 million shares of our common stock (1.9 million shares each from Citi and JPM). We recorded the payments to Citi and JPM as a reduction to stockholders' equity, consisting of an $1.5 billion increase in treasury stock, which reflects the value of the initial 3.8 million shares received upon initial settlement, and a $262.5 million decrease in capital in excess of par value, which reflects the value of stock held back by Citi and JPM pending final settlement of the December 2020 ASR Agreements. The final number of shares that we may receive, or be required to remit, under the December 2020 ASR Agreements, will be determined based on the daily volume-weighted average share price of our common stock over the term of the December 2020 ASR Agreements, less a discount and subject to adjustments pursuant to the terms and conditions of the December 2020 ASR Agreements. We expect final settlement under the December 2020 Agreements to occur during the second quarter of 2021. The December 2020 Agreements contain provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement of the agreement may be accelerated, extended, or terminated early by Citi, JPM or Humana as well as various acknowledgments and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our common stock from Citi and JPM or we may be required to make a payment. If we are obligated to make a payment, we may elect to satisfy such obligation in cash or shares of our common stock.

(2) Excludes 0.2 million shares repurchased in connection with employee stock plans.

(3) On February 18, 2021, the Board of Directors replaced the previous share repurchase authorization of up to $3 billion (of which approximately $250 million remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring as of February 18, 2024.

ITEM 6. SELECTED FINANCIAL DATA

Not applicable.

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

For discussion of 2018 items and year-over-year comparisons between 2019 and 2018 that are not included in this 2020 Form 10-K, refer to "Item 7. – Management Discussion and Analysis of Financial Condition and Results of Operations" found in our Form 10-K for the year ended December 31, 2019, that was filed with the Securities and Exchange Commission on February 20, 2020.

Executive Overview

General

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

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

COVID-19

During 2020 we took actions to protect, inform, and care for our members, providers, employees, and other stakeholders associated with the outbreak of the novel coronavirus, or COVID-19. Specifically, we highlight the following actions to support our members:

- waiving all cost sharing for COVID-19 treatment and testing, including inpatient hospital admissions as well as in-network primary care, outpatient behavioral health, and telehealth visits, to reduce financial barriers to members seeking care and to re-engage with their physician, while continuing to encourage the use of telehealth;
- delivering meals to our senior members in need;
- making it easier for members to be tested for COVID-19 by offering at-home testing, as well as offering in-home preventive screening and diabetes testing kits to encourage members to seek preventive care that may have been delayed during the pandemic.
- proactively delivering safety kits, including face masks, to members and employee homes to facilitate access to care and support visits to providers safely;
- extending grace periods for premium payments for our fully-insured commercial group members, to ensure continuity of coverage during times of financial stress; and
- establishing a clinical outreach team to proactively engage with our most vulnerable members.

In addition, we took steps to support our provider partners and boost system viability by:

- increasing provider funding, simplifying and expanding claims processing and releasing advanced funding to providers, to get reimbursement payments to providers as quickly as possible and ease financial concerns so that members are able to continue to access the care and information they need; and

- expanding modifications to certain utilization management processes, to ease administrative stress and make sure providers are able to most efficiently care for their patients.

We also supported our workforce keeping them safe and addressing other needs during this time, highlighting the following:

- transitioning nearly 94% of the workforce to work-at-home and equipping them with the necessary technology and resources for a successful remote work environment.
- providing funding for emergency relief for elder and child caregiving and financial hardship from family job loss, food insecurity and household essentials.
- adjusting pay and leave policies to provide additional paid time off to manage personal challenges as a result of COVID-19 including school closings and child care.

Finally, we continued to support the communities we serve by donating $200 million to the Humana Foundation to address social determinants of health in an effort to promote more health days and encourage greater health equity.

The emergence and spread of COVID-19 has impacted our business. Beginning in the second half of March 2020, the implementation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity resulted in the temporary deferral of non-essential care and significant reduction in hospital admissions and overall healthcare system utilization during April 2020. Non-COVID utilization then began to increase during May and June 2020, and continued to rebound throughout the third quarter and early in the fourth quarter of 2020, reaching approximately 95% of historic baseline levels as of the end of October 2020. Then, in the latter half of November and accelerating throughout the month of December, we experienced a significant increase in COVID-19 admissions in nearly all of the markets in which we operate across our Medicare Advantage, Medicaid, and group commercial insurance business lines, resulting in higher COVID-19 treatment and testing costs. During this period, we also experienced a corresponding decline in non-COVID utilization in all service categories to well below the near baseline levels of non-COVID utilization witnessed as late as the end of October 2020 (with non-COVID utilization in our Medicare Advantage business running approximately 15% below normal levels at the close of the fourth quarter of 2020). The impact of this decline in non-COVID utilization more than offset the higher COVID-19 treatment and testing costs during this period. Our 2020 results were also impacted by our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model.

We currently anticipate that the higher levels of COVID-19 admissions experienced late in 2020, and the corresponding decrease in non-COVID utilization, will continue for at least the first few months of 2021. Over the course of 2021, we then expect COVID utilization to decline as more of our members are vaccinated, and that non-COVID utilization will trend back to more normal levels. The significant disruption in utilization during 2020, and in particular the unanticipated decline in non-COVID utilization in November and December, also impacted our ability to implement clinical initiatives to manage health care costs and chronic conditions of our members, and appropriately document their risk profiles. We currently expect this may impact our 2021 revenues under the risk adjustment payment model for Medicare Advantage plans, but that these trends will also normalize in 2022 as non-COVID utilization trends back to more normal levels throughout 2021. However, the course and magnitude of these trends and their associated impact remains highly uncertain and subject to a significant number of variables and uncertainties including, among others, the severity and duration of the pandemic, continued actions taken to mitigate the spread of COVID-19 (including new COVID-19 variants) and in turn, relax those restrictions, the timing and degree in resumption of demand for deferred health care services, the pace of administration of COVID-19 vaccines and the effectiveness of those vaccines, and level and cost of treatment and testing, all of which are difficult to predict. As such, our response to this global health crisis and the subsequent recovery will continue to evolve over the coming months.

Business Segments

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable 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, the Chief Operating Decision Maker, to assess performance and allocate resources. See Note 18 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes our military services business, primarily our TRICARE T2017 East 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, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our non-consolidating minority investment in Kindred at Home and the strategic partnership with WCAS to develop and operate senior-focused, payor-agnostic, primary care centers.

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

Seasonality

COVID-19 disrupted the pattern of our quarterly earnings and operating cash flows in 2020 largely due to the temporary deferral of non-essential care which resulted in significant reductions in hospital admissions and lower overall healthcare system utilization during higher levels of COVID-19 hospital admissions. Similar impacts and seasonal disruptions from either higher or lower utilization are expected to persist as we respond to and recover from the COVID-19 global health crisis.

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

in the latter stages. As a result, the PDP benefit ratio generally decreases as the year progresses. In addition, the number of low income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

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

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

Recent Transactions

In the first quarter of 2020, we purchased privately held Enclara Healthcare, or Enclara, one of the nation's largest hospice pharmacy and benefit management providers for cash consideration of approximately $709 million, net of cash received.

Also, in the first quarter of 2020, we entered into a strategic partnership with WCAS to accelerate the expansion of our primary care model. The WCAS partnership opened 20 payor-agnostic, senior-focused primary care centers during 2020, and is expected to open an additional 30 over the next 2 years.

These transactions are more fully discussed in Note 3 to the consolidated financial statements.

Highlights

- Our 2020 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, 2020, approximately 2,650,100 members, or 67%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 2,407,000 members, or 67%, at December 31, 2019. Medicare Advantage and dual demonstration program membership enrolled in a Humana chronic care management program was 910,600 at December 31, 2020, an increase of 4.8% from 868,800 at December 31, 2019. These members may not be unique to each program since members have the ability to enroll in multiple programs. The increase is driven by our improved process for identifying and enrolling members in the appropriate program at the right time, coupled with growth in Special Needs Plans, or SNP, membership.
- On January 15, 2021, Centers for Medicare & Medicaid Services, or CMS, published its Announcement of Calendar Year 2022 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies, or the Final Rate Notice. We expect the Final Rate Notice to result in a 3.7% rate increase for non end stage renal disease, or ESRD, Medicare Advantage business, excluding the impact of Employer Group Waiver Plan, or EGWP, funding changes. Our 3.7% rate increase compares to CMS's estimate for the sector of 4.08% on a comparable basis, with the variance primarily driven by county rebasing and our geographic footprint. CMS also establishes separate rates of payment for ESRD beneficiaries enrolled in Medicare Advantage plans. We expect the Final Rate Notice to result in a 5.0% rate increase in 2021 for ESRD beneficiaries. Our estimate of 5.0% is equivalent to CMS's estimate.

The 2022 benchmark increase of 3.7% includes roughly 0.8% for the projected cost of COVID-19 vaccines.

- Net income was $3.4 billion for 2020 compared to $2.7 billion in 2019 and earnings per diluted common share increased $5.21 from $20.10 earnings per diluted common share in 2019 to $25.31 earnings per diluted common share in 2020. These comparisons were significantly impacted by the change in the fair value of publicly-traded equity securities, the net receipt of commercial risk corridor receivables previously written off, and the put/call valuation adjustments associated with certain equity method investments. The change in the fair value of our publicly-traded equity securities relates primarily to our common stock holdings, including both the gain resulting from the initial conversion of our prior ownership interest in certain privately held companies, primarily in Oak Street Health, Inc., or OSH, into common stock upon such companies' initial public offering, or IPO, during the third quarter of 2020, and the subsequent changes in the market value of such securities from their IPO through the end of 2020. In 2020 we received $578 million, net of related fees and expenses pursuant to the U.S. Supreme Court ruling that the government is obligated to pay the losses under the risk corridor program. The receipt of the risk corridor payments was associated with losses incurred under the Health Care Reform business in 2014 to 2016. The receipt of these risk corridor payments accounted for less than half of our accumulated losses before income taxes from this business during that time period. The impact of these adjustments to our consolidated income before income taxes and equity in net earnings and diluted earnings per common share was as follows for 2020.

	2020	2019
Consolidated income before income taxes and equity in net earnings:		
Change in the fair value of publicly-traded equity securities	$ 745	$ —
Receipt of commercial risk corridor receivables previously written-off	578	—
Put/call valuation adjustments	(103)	506
	$ 1,220	$ 506

	2020	2019
Diluted earnings per common share:		
Change in the fair value of publicly-traded equity securities	$ 4.32	$ —
Receipt of commercial risk corridor receivables previously written-off	3.35	—
Put/call valuation adjustments	(0.60)	2.89
	$ 7.07	$ 2.89

- Excluding these adjustments, our results of operations reflect the impact of the ongoing COVID-19 pandemic. Comparisons were impacted by cost reductions due to lower non-COVID utilization patterns from stay-at-home and physical distancing orders and other restrictions on movement offset by cost increases due to COVID-19 treatment and testing costs and our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model. These changes were also favorably impacted by a lower number of shares used to compute dilutive earnings per common share, primarily reflecting share repurchases completed during 2019, partially offset by a higher tax rate resulting from the return of the non-deductible health insurance industry fee in 2020.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases our effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative, judicial or regulatory changes such as the Families First Coronavirus Response Act (the "Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and other legislative or regulatory action taken in response to COVID-19 including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, or increases in regulation of our prescription drug benefit businesses, 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 assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail and Group and Specialty segment customers and are described in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data in this 2020 Form 10-K.

Comparison of Results of Operations for 2020 and 2019

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2020 and 2019:

Consolidated

			Change	
	2020	2019	Dollars	Percentage
		(dollars in millions, except per common share results)		
Revenues:				
Premiums:				
Retail	$ 67,124	$ 56,254	$ 10,870	19.3 %
Group and Specialty	6,460	6,694	(234)	(3.5)%
Corporate	602	—	602	100.0 %
Total premiums	74,186	62,948	11,238	17.9 %
Services:				
Retail	19	17	2	11.8 %
Group and Specialty	780	790	(10)	(1.3)%
Healthcare Services	1,016	632	384	60.8 %
Total services	1,815	1,439	376	26.1 %
Investment income	1,154	501	653	130.3 %
Total revenues	77,155	64,888	12,267	18.9 %
Operating expenses:				
Benefits	61,628	53,857	7,771	14.4 %
Operating costs	10,052	7,381	2,671	36.2 %
Depreciation and amortization	489	458	31	6.8 %
Total operating expenses	72,169	61,696	10,473	17.0 %
Income from operations	4,986	3,192	1,794	56.2 %
Interest expense	283	242	41	16.9 %
Other expense (income), net	103	(506)	609	(120.4)%
Income before income taxes and equity in net earnings	4,600	3,456	1,144	33.1 %
Provision for income taxes	1,307	763	544	71.3 %
Equity in net earnings	74	14	60	428.6 %
Net income	$ 3,367	$ 2,707	$ 660	24.4 %
Diluted earnings per common share	$ 25.31	$ 20.10	$ 5.21	25.9 %
Benefit ratio (a)	83.1 %	85.6 %		(2.5)%
Operating cost ratio (b)	13.2 %	11.5 %		1.7 %
Effective tax rate	28.0 %	22.0 %		6.0 %

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

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

Premiums Revenue

Consolidated premiums increased $11.2 billion, or 17.9%, from $62.9 billion for 2019 to $74.2 billion for 2020 primarily due to higher premium revenues from Medicare Advantage and state-based contracts membership growth, higher per member Medicare Advantage premiums, and the receipt of commercial risk corridor receivables previously written off, partially offset by the impact of declining stand-alone PDP and fully-insured group commercial medical membership as more fully described in the detailed segment results discussion that follows.

Services Revenue

Consolidated services revenue increased $376 million, or 26.1%, from $1.4 billion for 2019 to $1.8 billion for 2020, primarily due to an increase in services revenue in the Healthcare Services segment associated with higher external pharmacy revenues resulting from the Enclara acquisition in the first quarter of 2020.

Investment Income

Investment income was $1.2 billion for 2020, increasing $653 million, or 130.3%, from 2019, primarily due to the $745 million change in fair value of publicly-traded equity securities during 2020.

Benefits Expense

Consolidated benefits expense was $61.6 billion for 2020, an increase of $7.8 billion, or 14.4%, from 2019. The consolidated benefit ratio for 2020 was 83.1%, a decrease of 250 basis points from 2019 primarily reflecting significantly depressed non-COVID utilization in the first half of 2020 as well as the last two months of the fourth quarter, the reinstatement of the non-deductible health insurance industry fee in 2020 that was contemplated in the pricing and benefit design of our products, along with the receipt of the commercial risk corridor receivables previously written off. These decreases were partially offset by the meaningful COVID-19 treatment and testing costs along with our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model, as well as lower prior-period medical claims reserve development.

We experienced favorable medical claims reserve development related to prior fiscal years of $313 million in 2020 and $336 million in 2019. The favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 40 basis points in 2020 and 50 basis points in 2019.

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 $2.7 billion, or 36.2%, from 2019 to $10.1 billion in 2020 reflecting an increase in operating costs in the Retail and the Group and Specialty segments as discussed in the detailed segment results discussion that follows.

The consolidated operating cost ratio for 2020 was 13.2%, increasing 170 basis points from 11.5% in 2019 primarily due to the reinstatement of the non-deductible health insurance industry fee in 2020, COVID-19 related administrative costs, including those associated with purchasing personal protective equipment for our clinicians and the build-out of infrastructure necessary to support employees working remotely. Higher marketing spend associated with the Medicare Annual Election Period, or AEP, strategic investments in our integrated care delivery model and continued support for our constituents, including a $200 million contribution to the Humana Foundation to support the communities served by us, particularly those with social and health disparities, also contributed to the increase. These increases were partially offset by scale efficiencies associated with growth in our Medicare Advantage membership, significant operating cost efficiencies in 2020 driven by previously disclosed productivity initiatives, and the net impact of the receipt of the commercial risk corridor receivables previously written off. The nondeductible health insurance industry fee impacted the operating cost ratio by 160 basis points in 2020.

Depreciation and Amortization

Depreciation and amortization in 2020 totaled $489 million compared to $458 million in 2019, an increase of 6.8%, primarily due to capital expenditures.

Interest Expense

Interest expense was $283 million for 2020 compared to $242 million for 2019, an increase of $41 million, or 16.9%. This increase primarily was due to the higher average borrowings outstanding.

Income Taxes

Our effective tax rate during 2020 was 28.0% compared to the effective tax rate of 22.0% in 2019. This change primarily was due to the reinstatement of the non-deductible health insurance industry fee in 2020. See Note 12 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

			Change	
	2020	2019	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	3,962,700	3,587,200	375,500	10.5 %
Group Medicare Advantage	613,200	525,300	87,900	16.7 %
Medicare stand-alone PDP	3,866,700	4,365,200	(498,500)	(11.4)%
Total Retail Medicare	8,442,600	8,477,700	(35,100)	(0.4)%
State-based Medicaid	772,400	469,000	303,400	64.7 %
Medicare Supplement	335,600	298,400	37,200	12.5 %
Total Retail medical members	9,550,600	9,245,100	305,500	3.3 %

			Change	
	2020	2019	Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 51,697	$ 43,128	$ 8,569	19.9 %
Group Medicare Advantage	7,774	6,475	1,299	20.1 %
Medicare stand-alone PDP	2,742	3,165	(423)	(13.4)%
Total Retail Medicare	62,213	52,768	9,445	17.9 %
State-based Medicaid	4,223	2,898	1,325	45.7 %
Medicare Supplement	688	588	100	17.0 %
Total premiums	67,124	56,254	10,870	19.3 %
Services	19	17	2	11.8 %
Total premiums and services revenue	$ 67,143	$ 56,271	$ 10,872	19.3 %
Segment earnings	$ 3,017	$ 2,235	$ 782	35.0 %
Benefit ratio	84.2 %	86.4 %		(2.2)%
Operating cost ratio	11.0 %	9.4 %		1.6 %

Segment Earnings

- Retail segment earnings were $3.0 billion in 2020, an increase of $782 million, or 35.0%, compared to $2.2 billion in 2019 primarily resulting from the net favorable impact of a lower benefit ratio, partially offset by a higher operating cost ratio as more fully described below.

Enrollment

- Individual Medicare Advantage membership increased 375,500 members, or 10.5%, from 3,587,200 members as of December 31, 2019 to 3,962,700 members as of December 31, 2020, primarily due to membership additions associated with the 2020 Annual Election Period, or AEP, continued enrollment due to special elections, age-ins, and and Dual Eligible Special Need Plans, or D-SNP, members as well as the 2020 Open Election Period, or OEP, for Medicare beneficiaries. The 2020 OEP sales period, which ran from January 1 to March 31, 2020, added approximately 30,000 members. individual Medicare Advantage membership includes 406,100 D-SNP members as of December 31, 2020, a net increase of 117,900, or 40.9%, from 288,200 December 31, 2019. For the full year 2021, we anticipate a net membership increase in our individual Medicare Advantage offerings of 425,000 members to 475,000 members.
- Group Medicare Advantage membership increased 87,900 members, or 16.7%, from 525,300 members as of December 31, 2019 to 613,200 members as of December 31, 2020, primarily due to the addition of a large account in January 2020, along with net membership additions associated with the 2020 selling season. For the full year 2021, we anticipate a net membership decline in our Group Medicare Advantage offerings of approximately 50,000 members.
- Medicare stand-alone PDP membership decreased 498,500 members, or 11.4%, from 4,365,200 members as of December 31, 2019 to 3,866,700 members as of December 31, 2020, primarily resulting from terminations driven by premium and benefit adjustments experienced by members that were previously enrolled in our 2019 Humana Walmart Rx plan and the 2019 Humana Enhanced plan, which were consolidated into the Premier Rx plan in 2020. The PDP losses were partially offset by growth in the new low-price Humana Walmart Value Rx plan, driven by both new sales and plan to plan changes. For the full year 2021, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of approximately 300,000 members.
- State-based Medicaid membership increased 303,400 members, or 64.7%, from 469,000 members as of December 31, 2019 to 772,400 members as of December 31, 2020, primarily reflecting the impact of discontinuing the reinsurance agreement with CareSource and the assumption of full financial risk for the existing Kentucky Medicaid contract as of January 1, 2020, as well as additional enrollment resulting from the current economic downturn due to the COVID-19 pandemic.

Premiums revenue

- Retail segment premiums increased $10.9 billion, or 19.3%, from 2019 to 2020 primarily due to higher premiums as a result of Medicare Advantage and state-based contracts membership growth and higher per member Medicare Advantage premiums. These favorable items were partially offset by the decline in membership in our stand-alone PDP offerings.

Benefits expense

- The Retail segment benefit ratio of 84.2% for 2020 decreased 220 basis points from 86.4% in 2019 primarily reflecting significantly depressed non-COVID utilization in the first half of 2020 as well as in the last two months of 2020 and the reinstatement of the non-deductible health insurance industry fee in 2020 which was contemplated in the pricing and benefit design of our products. These were partially offset by meaningful COVID-19 treatment costs and testing, our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model, the impact from a shift in Medicare membership mix, and lower favorable prior-period medical claims reserve development.

- The Retail segment's benefits expense for 2020 included the beneficial effect of $266 million in favorable prior-year medical claims reserve development versus $386 million in 2019. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 40 basis points in 2020 versus approximately 70 basis points in 2019.

Operating costs

- The Retail segment operating cost ratio of 11.0% for 2020 increased 160 basis points from 9.4% in 2019 primarily due to the reinstatement of the non-deductible health insurance industry fee in 2020, COVID-19 related administrative costs as previously discussed, continued support for our constituents and strategic investments in our integrated care delivery model, and increased spending associated with Medicare AEP. These were partially offset by scale efficiencies associated with growth in our Medicare Advantage membership and significant operating cost efficiencies driven by previously disclosed productivity initiatives.
- The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2020.

Group and Specialty Segment

	2020	2019	Change Members	Change Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	777,400	908,600	(131,200)	(14.4)%
ASO	504,900	529,200	(24,300)	(4.6)%
Military services	5,998,700	5,984,300	14,400	0.2 %
Total group medical members	7,281,000	7,422,100	(141,100)	(1.9)%
Specialty membership (a)	5,310,300	5,425,900	(115,600)	(2.1)%

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

	2020	2019	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 4,761	$ 5,123	$ (362)	(7.1)%
Specialty	1,699	1,571	128	8.1 %
Total premiums	6,460	6,694	(234)	(3.5)%
Services	780	790	(10)	(1.3)%
Total premiums and services revenue	$ 7,240	$ 7,484	$ (244)	(3.3)%
Segment (loss) earnings	$ (143)	$ 28	$ (171)	(610.7)%
Benefit ratio	85.6 %	86.0 %		(0.4)%
Operating cost ratio	25.0 %	22.0 %		3.0 %

Segment Earnings

- Group and Specialty segment loss was $143 million in 2020, a decrease of $171 million, or 610.7%, from $28 million of segment earnings in 2019 primarily due to the net negative impact of a higher operating cost ratio, partially offset by a slightly lower benefit ratio as more fully described below.

Enrollment

- Fully-insured commercial group medical membership decreased 131,200 members, or 14.4% from 908,600 members as of December 31, 2019 primarily reflecting lower membership in small group accounts due in part to more small group accounts selecting level-funded ASO products, as well as the loss of certain large group accounts due to disciplined pricing in the competitive environment. Additionally, the declines in membership were impacted by the current economic downturn driven by the COVID-19 pandemic resulting in higher unemployment rates and loss of coverage for fully-insured commercial group members. The portion of group fully-insured commercial medical membership in small group accounts was approximately 54% at December 31, 2020 and 59% at December 31, 2019.
- Group ASO commercial medical membership decreased 24,300 members, or 4.6%, from 529,200 members as of December 31, 2019 to 504,900 members as of December 31, 2020 primarily reflecting the loss of certain large group accounts due to continued discipline in pricing of services for self-funded accounts amid a highly competitive environment and the impact of the current economic downturn driven by the COVID-19 pandemic as previously discussed, partially offset by more small group accounts selecting level-funded ASO products. Small group membership comprised 45% of group ASO medical membership at December 31, 2020 versus 40% at December 31, 2019.
- Military services membership increased 14,400 members, or 0.2%, from 5,984,300 members as of December 31, 2019 to 5,998,700 members as of December 31, 2020. Membership includes military service members, retirees, and their families to whom we are providing healthcare services under the current TRICARE East Region contract.
- Specialty membership decreased 115,600 members, or 2.1%, from 5,425,900 as of December 31, 2019 to 5,310,300 members as of December 31, 2020 primarily due to the loss of certain group accounts offering stand-alone dental and vision products, as well as the impact of the current economic downturn driven by the COVID-19 pandemic as previously discussed.

Premiums revenue

- Group and Specialty segment premiums decreased $234 million, or 3.5%, from $6.7 billion in 2019 to $6.5 billion in 2020, primarily due to the decline in our fully-insured group commercial membership, partially offset by higher stop-loss premiums related to our level-funded ASO accounts resulting from membership growth in this product and higher per member premiums across the fully-insured commercial business.

Services revenue

- Group and Specialty segment services revenue decreased $10 million, or 1.3%, from 2019 to 2020 primarily due to lower ASO membership described previously.

Benefits expense

- The Group and Specialty segment benefit ratio decreased 40 basis points from 86.0% in 2019 to 85.6% in 2020 primarily due to significantly depressed non-COVID utilization in the first half of 2020 and again in the last two months of 2020, the reinstatement of the non-deductible health insurance industry fee in 2020 which was contemplated in the pricing and benefit design of our products, and higher favorable prior-period medical claims reserve development. These items were partially offset by meaningful COVID-19 treatment costs and testing and our ongoing pandemic relief efforts and strategic investments as previously described.

- The Group and Specialty segment's benefits expense included the favorable effect of $47 million in prior-period medical claims reserve development in 2020 versus the unfavorable effect of $50 million in favorable prior-period medical claims reserve development in 2019. This favorable prior-period medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2020 while the unfavorable prior-period medical claims reserve development increased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2019.

Operating costs

- The Group and Specialty segment operating cost ratio of 25.0% for 2020 increased 300 basis points from 22.0% for 2019, primarily due to COVID-19 related administrative costs as previously discussed, continued support for our constituents and strategic investments in the segment to position the business for long-term success, and the reinstatement of the non-deductible health insurance industry fee in 2020. These increases were partially offset by significant operating cost efficiencies driven by previously disclosed productivity initiatives.

- The non-deductible health insurance industry fee increased the operating cost ratio by approximately 130 basis points in 2020.

Healthcare Services Segment

			Change	
	2020	2019	Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$ 107	$ 140	$ (33)	(23.6)%
Pharmacy solutions	581	186	395	212.4 %
Provider services	328	306	22	7.2 %
Total services revenues	1,016	632	384	60.8 %
Intersegment revenues:				
Pharmacy solutions	24,587	22,189	2,398	10.8 %
Provider services	2,266	2,344	(78)	(3.3)%
Clinical care services	566	616	(50)	(8.1)%
Total intersegment revenues	27,419	25,149	2,270	9.0 %
Total services and intersegment revenues	$ 28,435	25,781	$ 2,654	10.3 %
Segment earnings	$ 944	$ 789	$ 155	19.6 %
Operating cost ratio	96.3 %	96.4 %		(0.1)%

Segment Earnings

- Healthcare Services segment earnings were $944 million in 2020, an increase of $155 million, or 19.6%, from 2019 reflecting the same factors that resulted in a lower operating cost ratio as more fully described below, as well as higher earnings from equity method investments in 2020.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 478 million in 2020, up 4.8% versus scripts of approximately 456 million in 2019. The increase primarily was driven by higher Medicare Advantage and state-based contracts membership, partially offset by the decline in stand-alone PDP membership.

Services revenue

- Services revenue increased $384 million, or 60.8%, from 2019 to $1.0 billion for 2020 primarily due to the additional pharmacy revenues associated with the acquisition of Enclara in 2020.

Intersegment revenues

- Intersegment revenues increased $2.3 billion, or 9.0%, from 2019 to $27.4 billion for 2020 primarily due to strong Medicare Advantage membership growth and a slight shift by members to 90-day mail supply, partially offset by the loss of intersegment revenues associated with the decline in stand-alone PDP membership.

Operating costs

- The Healthcare Services segment operating cost ratio of 96.3% for 2020 decreased 10 basis points from 96.4% in 2019 due to operational improvements and reduced utilization resulting from COVID-19 in our provider services business, as well as significant operating cost efficiencies in 2020 driven by previously disclosed productivity initiatives. These decreases were partially offset by COVID-19 administrative related costs, including expenses associated with additional safety measures taken for our pharmacy, provider, and clinical teams who have continued to provide services to members during the COVID-19 pandemic. The increase further reflects higher costs incurred in the pharmacy business to ensure timely delivery of prescriptions amid the COVID-19 pandemic and additional investments in the segment's provider business related to marketing and AEP initiatives.

Liquidity

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

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2020 Form 10-K.

Cash and cash equivalents increased to $4.7 billion at December 31, 2020 from $4.1 billion at December 31, 2019. The change in cash and cash equivalents for the years ended December 31, 2020, 2019 and 2018 is summarized as follows:

	2020	2019	2018
		(in millions)	
Net cash provided by operating activities	$ 5,639	$ 5,284	$ 2,173
Net cash used in investing activities	(3,065)	(1,278)	(3,087)
Net cash used in financing activities	(1,955)	(2,295)	(785)
Increase (decrease) in cash and cash equivalents	$ 619	$ 1,711	$ (1,699)

Cash Flow from Operating Activities

The increase in operating cash flows in 2020 was primarily due to the impact of higher earnings and the timing of working capital items, in particular; the impact of Medicare Advantage membership growth on IBNR, described below, as claim payments related to new members lag the related premium collected.

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

The detail of benefits payable was as follows at December 31, 2020, 2019 and 2018:

	2020	2019	2018	Change 2020
		(in millions)		
IBNR (1)	$ 5,290	$ 4,150	$ 3,361	$ 1,140
Reported claims in process (2)	816	628	617	188
Other benefits payable (3)	2,037	1,226	884	811
Total benefits payable	$ 8,143	$ 6,004	$ 4,862	2,139

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

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

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

The increase in benefits payable in 2020 was primarily due to an increase in IBNR, mainly as a result of Medicare Advantage membership growth. In addition, 2020 was impacted by an increase in the amounts owed to providers under capitated and risk sharing arrangements, primarily related to Medicare Advantage membership growth in risk sharing arrangements and higher provider surplus amounts driven by lower utilization due to COVID-19.

The detail of total net receivables was as follows at December 31, 2020, 2019 and 2018:

	2020	2019	2018	Change 2020
		(in millions)		
Medicare	$ 928	$ 835	$ 836	$ 93
Commercial and other	122	162	135	(40)
Military services	160	128	123	32
Allowance for doubtful accounts	(72)	(69)	(79)	(3)
Total net receivables	$ 1,138	$ 1,056	$ 1,015	82
Reconciliation to cash flow statement:				
Change in receivables disposed from sale of business				3
Change in receivables per cash flow statement resulting in cash used by operations				$ 85

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

Military services receivables at December 31, 2020, 2019, and 2018 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our TRICARE contracts.

Many provisions of the Health Care Reform Law became effective in 2014, including the non-deductible health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases our effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021. We paid the federal government annual health insurance industry fees of $1.18 billion in 2020.

Cash Flow from Investing Activities

In the first quarter of 2020, we acquired privately held Enclara for cash consideration of approximately $709 million, net of cash received as discussed in Note 3 to the consolidated financial statements included in Item 8 - Financial Statements and Supplementary Data.

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $964 million in 2020, $736 million in 2019, and $612 million in 2018. The increase in capital expenditures year over year was primarily due to information technology expenditures supporting our integrated care delivery model.

In 2018, we completed the sale of our wholly-owned subsidiary KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. Total cash and cash equivalents, including parent company funding, disposed at the time of sale, was $805 million. See Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

During 2018 we paid cash consideration of approximately $1.1 billion to acquire a 40% minority interest in Kindred at Home, $169 million to acquire the remaining interest in MCCI Holdings, LLC, or MCCI, and $185 million to acquire all of Family Physicians Group, or FPG, as discussed in Notes 3 and 4 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income debt securities, totaling $1.4 billion, $542 million, and $221 million, during 2020, 2019 and 2018, respectively.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Claim payments were higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk by $938 million, $560 million and $653 million in the 2020, 2019 and 2018 periods, respectively. Our net receivable from CMS for subsidies and brand name prescription drug discounts was $1.2 billion at December 31, 2020 compared to a net receivable of $229 million at December 31, 2019.

Under our administrative services only TRICARE contract, health care costs payments for which we do not assume risk exceeded reimbursements from the federal government by $1 million and $63 million in the 2020 and 2019 periods, respectively, and reimbursements from the federal government exceeded health care costs payments for which we do not assume risk by $38 million in the 2018 period.

Claim payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were $25 million in the 2018 period.

In December 2020, we repaid $400 million aggregate principal amount of our 2.5% senior notes due on their maturity date of December 15, 2020.

In March 2020, we issued $600 million of 4.500% senior notes due April 1, 2025 and $500 million of 4.875% senior notes due April 1, 2030. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid were $1,088 million.

In March 2020, we drew $1 billion on our existing term loan commitment and repaid the $1 billion outstanding amount in November 2020.

In August 2019, we issued $500 million of 3.125% senior notes due August 15, 2029 and $500 million of 3.950% senior notes due August 15, 2049. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid were $987 million. We used the net proceeds from this offering, together with available cash, to repay the $650 million outstanding amount due under our term note in August 2019, and the $400 million aggregate principal amount of our 2.625% senior notes due on its maturity date of October 1, 2019.

In November 2018, we entered into a $1.0 billion term note agreement with a bank at a variable rate of interest due within one year. We repaid $350 million of the outstanding amount in 2018. For a detailed discussion of our debt please refer to Note 13 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We repurchased common shares for $1.82 billion, $1.07 billion and $1.09 billion in 2020, 2019 and 2018 under share repurchase plans authorized by the Board of Directors and in connection with employee stock plans.

We paid dividends to stockholders of $323 million in 2020, $291 million in 2019, and $265 million in 2018.

We entered into a commercial paper program in October 2014. Net proceeds from issuance of commercial paper were $295 million in 2020 and the maximum principal amount outstanding at any one time during 2020 was $600 million. Net repayments from the issuance of commercial paper were $360 million in 2019 and the maximum principal amount outstanding at any one time during 2019 was $801 million. Net proceeds from issuance of commercial paper were $485 million in 2018 and the maximum principal amount outstanding at any one time during 2018 was $923 million.

The remainder of the cash used in or provided by financing activities in 2020, 2019, and 2018 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

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

Stock Repurchases

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

Debt

In December 2020, we repaid $400 million aggregate principal amount of our 2.5% senior notes due on their maturity date of December 15, 2020.

In March 2020, we issued $600 million of 4.500% senior notes due April 1, 2025 and $500 million of 4.875% senior notes due April 1, 2030. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid, were approximately $1,088 million as of December 31, 2020. We used the net proceeds for general corporate purposes.

In February 2020, we entered into a new $1 billion term loan commitment with a bank that matures 1 year after the first draw, subject to a 1 year extension. In March 2020, we made a draw on the entire term loan commitment of $1 billion. The facility fee, interest rate and financial covenants are consistent with those of our revolving credit agreement. The note was prepayable without penalty. We repaid the $1 billion outstanding balance in November 2020.

For a detailed discussion of our debt, including our senior notes, credit agreement and commercial paper program, please refer to Note 13 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Acquisitions and Divestiture

During 2020, we completed the acquisition of privately held Enclara, one of the nation's largest hospice pharmacy and benefit management providers for cash consideration of approximately $709 million, net of cash received. For a detailed discussion of our acquisitions and divestitures, please refer to Notes 3 and 4 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Liquidity Requirements

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

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2020 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $250 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis

points, or annual interest expense by $1 million, up to a maximum 100 basis points, or annual interest expense by $3 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company decreased to $772 million at December 31, 2020 from $1.4 billion at December 31, 2019. This decrease primarily reflects common stock repurchases, insurance subsidiaries' capital contributions, repayment of debt and capital expenditures partially offset by insurance subsidiaries dividends, non-insurance subsidiaries' profits and net proceeds from debt issuance. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated insurance subsidiaries paid dividends to our parent company of $1.3 billion in 2020, $1.8 billion in 2019, and $2.3 billion in 2018. Subsidiary capital requirements from significant premium growth has impacted the amount of regulated subsidiary dividends over the last two years. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. The amount of ordinary dividends that may be paid to our parent company in 2021 is approximately $1.4 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to our parent, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Off-Balance Sheet Arrangements

As of December 31, 2020, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Critical Accounting Policies and Estimates

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

Benefits Expense Recognition

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

	December 31, 2020	Percentage of Total	December 31, 2019	Percentage of Total
	(dollars in millions)			
IBNR	$ 5,290	65.0 %	$ 4,150	69.1 %
Reported claims in process	816	10.0 %	628	10.5 %
Other benefits payable	2,037	25.0 %	1,226	20.4 %
Total benefits payable	$ 8,143	100.0 %	$ 6,004	100.0 %

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

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderately adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2020 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
0.70%	$(348)	3.00%	$(332)
0.60%	$(298)	2.75%	$(304)
0.50%	$(249)	2.50%	$(276)
0.40%	$(199)	2.25%	$(249)
0.30%	$(149)	2.00%	$(221)
0.20%	$(99)	1.75%	$(194)
0.10%	$(50)	1.50%	$(166)

(a) Reflects estimated potential changes in benefits payable at December 31, 2020 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2020 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

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

The following table provides a historical perspective regarding the accrual and payment of our benefits payable. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail and Group and Specialty segment tables including information about incurred and paid claims development as of December 31, 2020, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2020	2019	2018
	(in millions)		
Balances at January 1	$ 6,004	$ 4,862	$ 4,668
Less: Reinsurance recoverables	(68)	(95)	(70)
Balances at January 1, net	5,936	4,767	4,598
Incurred related to:			
Current year	61,941	54,193	46,385
Prior years	(313)	(336)	(503)
Total incurred	61,628	53,857	45,882
Paid related to:			
Current year	(54,003)	(48,421)	(41,736)
Prior years	(5,418)	(4,267)	(3,977)
Total paid	(59,421)	(52,688)	(45,713)
Reinsurance recoverable	—	68	95
Balances at December 31	$ 8,143	$ 6,004	$ 4,862

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

	Favorable Development by Changes in Key Assumptions					
	2020		2019		2018	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (167)	(1.9)%	$ (233)	(3.1)%	$ (229)	(3.3)%
Completion factors	(146)	(0.3)%	(103)	(0.3)%	(274)	(0.8)%
Total	$ (313)		$ (336)		$ (503)	

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $313 million in 2020, $336 million in 2019, and $503 million in 2018. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2020, 2019, and 2018.

	(Favorable) Unfavorable Medical Claims Reserve Development			Change	
	2020	2019	2018	2020	2019
	(in millions)				
Retail Segment	$ (266)	$ (386)	$ (398)	$ 120	$ 12
Group and Specialty Segment	(47)	50	(46)	(97)	96
Individual Commercial Segment	—	—	(57)	—	57
Other Businesses	—	—	(2)	—	2
Total	$ (313)	$ (336)	$ (503)	$ 23	$ 167

The favorable medical claims reserve development for 2020, 2019, and 2018 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2020 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Revenue Recognition

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

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premiums from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and recognized ratably during the year with adjustments each period to reflect changes in the ultimate premium.

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

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses

data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare," and in Item 1A. - Risk Factors.

Investment Securities

Investment securities totaled $13.8 billion, or 39% of total assets at December 31, 2020, and $11.4 billion, or 39% of total assets at December 31, 2019. The investment portfolio was primarily comprised of debt securities, detailed below, at December 31, 2020 and entirely at December 31, 2019. The fair value of investment securities were as follows at December 31, 2020 and 2019:

	12/31/2020	Percentage of Total	12/31/2019	Percentage of Total
	(dollars in millions)			
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 616	4.5 %	$ 354	3.1 %
Mortgage-backed securities	3,254	23.6 %	3,710	32.6 %
Tax-exempt municipal securities	1,447	10.5 %	1,463	12.9 %
Mortgage-backed securities:				
Residential	17	0.1 %	—	— %
Commercial	1,318	9.6 %	804	7.1 %
Asset-backed securities	1,372	10.0 %	1,093	9.6 %
Corporate debt securities	4,927	35.8 %	3,947	34.7 %
Total debt securities	12,951	94.1 %	11,371	99.9 %
Common stock	815	5.9 %	7	0.1 %
Total investment securities	$ 13,766	100.0 %	$ 11,378	100.0 %

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2020. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 1% of our total debt securities. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2020:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 225	$ (1)	$ —	$ —	$ 225	$ (1)
Mortgage-backed securities	199	(1)	—	—	199	(1)
Tax-exempt municipal securities	16	—	19	—	35	—
Mortgage-backed securities:						
Residential	17	—	—	—	17	—
Commercial	193	(1)	43	—	236	(1)
Asset-backed securities	65	—	498	(2)	563	(2)
Corporate debt securities	342	(1)	16	—	358	(1)
Total debt securities	$ 1,057	$ (4)	$ 576	$ (2)	$ 1,633	$ (6)

Prior to January 1, 2020, we applied the other-than-temporary impairment model for securities in an unrealized loss position which did not result in any material impairments for 2019 or 2018. Beginning on January 1, 2020, we adopted the new current expected credit losses, or CECL, model which retained many similarities from the previous other-than-temporary impairment model except eliminating from consideration in the impairment analysis the length of time over which the fair value had been less than cost. Also, under the CECL model, expected losses on available for sale debt securities are recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities. For debt securities whose fair value is less than their amortized cost which we do not intend to sell or are not required to sell, we evaluate the expected cash flows to be received as compared to amortized cost and determine if an expected credit loss has occurred. In the event of an expected credit loss, only the amount of the impairment associated with the expected credit loss is recognized in income with the remainder, if any, of the loss recognized in other comprehensive income. To the extent we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value.

Potential expected credit loss impairment is considered using a variety of factors, including the 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 debt security; changes in the quality of the debt security's credit enhancement; payment structure of the debt security; changes in credit rating of the debt security by the rating agencies; failure of the issuer to make scheduled principal or interest payments on the debt security and changes in prepayment speeds. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. We estimate the amount of the expected credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The expected credit loss cannot exceed the full difference between the amortized cost basis and the fair value.

The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an

investment is related to a credit event requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or expected credit loss impairments may be recorded in future periods.

All issuers of debt securities we own that were trading at an unrealized loss at December 31, 2020 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2020, we did not intend to sell any debt securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these debt securities before recovery of their amortized cost basis. Additionally, we did not record any material credit allowances for debt securities that were in an unrealized loss position at December 31, 2020. There were no material other-than-temporary impairments in 2019 or 2018.

Goodwill and Long-lived Assets

At December 31, 2020, goodwill and other long-lived assets represented 20% of total assets and 52% of total stockholders' equity, compared to 21% and 50%, respectively, at December 31, 2019.

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

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in government reimbursement rates, the estimates underlying our goodwill impairment tests could be adversely affected. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. However, unfavorable changes in key assumptions or combinations of assumptions including a significant increase in the discount rate, decrease in the long-term growth rate or substantial reduction in our underlying cash flow assumptions, including revenue growth rates, medical and operating cost trends, and projected operating income could have a significant negative impact on the estimated fair value of our clinical and provider reporting units, which accounted for $524 million and $761 million, respectively. Impairment tests completed for 2020, 2019, and 2018 did not result in an impairment loss.

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

or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. In the past we have, and in the future we may enter into interest rate swap agreements depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $2.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. If drawn upon, the revolving credit would revert to using the alternative base rate once LIBOR is discontinued.There were no borrowings outstanding under our credit agreement at December 31, 2020 or December 31, 2019.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA- at December 31, 2020. Our net unrealized position increased $303 million from a net unrealized gain position of $211 million at December 31, 2019 to a net unrealized gain position of $514 million at December 31, 2020. At December 31, 2020, we had gross unrealized losses of $6 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. We did not record any material credit allowances for debt securities that were in an unrealized loss position during 2020. There were no material other-than-temporary impairments during 2019. While we believe that these impairments will be recovered and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 3.0 years as of December 31, 2020 and 2.5 years as of December 31, 2019. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $541 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2020 and 2019. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 10 year US treasury rates during the year have not exceeded 300 basis points, have changed between 200 and 300 basis points once, have changed between 100 and 200 basis points twice, and have changed by less than 100 basis points seven times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
			(in millions)			
As of December 31, 2020						
Investment income (a)	$ (44)	$ (33)	$ (21)	$ 91	$ 180	$ 270
Interest expense (b)	2	2	2	(6)	(12)	(18)
Pretax	$ (42)	$ (31)	$ (19)	$ 85	$ 168	$ 252
As of December 31, 2019						
Investment income (a)	$ (150)	$ (133)	$ (79)	$ 78	$ 157	$ 235
Interest expense (b)	10	9	4	(4)	(9)	(13)
Pretax	$ (140)	$ (124)	$ (75)	$ 74	$ 148	$ 222

(a) As of December 31, 2020 and 2019, some of our investments had interest rates below 1% and 2%, respectively, so the assumed hypothetical change in pretax earnings does not reflect the full 1% and 2%, respectively, point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2020 or December 31, 2019. There was $600 million and $300 million outstanding under our commercial paper program at December 31, 2020 and 2019, respectively. As of December 31, 2020 and 2019, our interest rate under our commercial paper program was less than 1% so the assumed hypothetical change in pretax earnings does not reflect the full 1% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2020	2019
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 4,673	$ 4,054
Investment securities	12,554	10,972
Receivables, less allowance for doubtful accounts of $72 in 2020 and $69 in 2019	1,138	1,056
Other current assets	5,276	3,806
Total current assets	23,641	19,888
Property and equipment, net	2,371	1,955
Long-term investment securities	1,212	406
Goodwill	4,447	3,928
Equity method investments	1,170	1,063
Other long-term assets	2,128	1,834
Total assets	$ 34,969	$ 29,074
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 8,143	$ 6,004
Trade accounts payable and accrued expenses	4,013	3,754
Book overdraft	320	225
Unearned revenues	318	247
Short-term debt	600	699
Total current liabilities	13,394	10,929
Long-term debt	6,060	4,967
Other long-term liabilities	1,787	1,141
Total liabilities	21,241	17,037
Commitments and contingencies (Note 17)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,648,742 shares issued at December 31, 2020 and 198,629,992 shares issued at December 31, 2019	33	33
Capital in excess of par value	2,705	2,820
Retained earnings	20,517	17,483
Accumulated other comprehensive income (loss)	391	156
Treasury stock, at cost, 69,787,614 shares at December 31, 2020 and 66,524,771 shares at December 31, 2019	(9,918)	(8,455)
Total stockholders' equity	13,728	12,037
Total liabilities and stockholders' equity	$ 34,969	$ 29,074

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

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2020	2019	2018
	(in millions, except per share results)		
Revenues:			
Premiums	$ 74,186	$ 62,948	$ 54,941
Services	1,815	1,439	1,457
Investment income	1,154	501	514
Total revenues	77,155	64,888	56,912
Operating expenses:			
Benefits	61,628	53,857	45,882
Operating costs	10,052	7,381	7,525
Depreciation and amortization	489	458	405
Total operating expenses	72,169	61,696	53,812
Income from operations	4,986	3,192	3,100
Loss on sale of business	—	—	786
Interest expense	283	242	218
Other expense (income), net	103	(506)	33
Income before income taxes and equity in net earnings	4,600	3,456	2,063
Provision for income taxes	1,307	763	391
Equity in net earnings	74	14	11
Net income	$ 3,367	$ 2,707	$ 1,683
Basic earnings per common share	$ 25.47	$ 20.20	$ 12.24
Diluted earnings per common share	$ 25.31	$ 20.10	$ 12.16

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

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2020	2019	2018
	(in millions)		
Net income	$ 3,367	$ 2,707	$ 1,683
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	393	450	(189)
Effect of income taxes	(89)	(105)	51
Total change in unrealized investment gains/losses, net of tax	304	345	(138)
Reclassification adjustment for net realized gains included in investment income	(90)	(34)	(53)
Effect of income taxes	20	8	17
Total reclassification adjustment, net of tax	(70)	(26)	(36)
Other comprehensive income (loss), net of tax	234	319	(174)
Comprehensive income (loss) attributable to equity method investments	1	(4)	(4)
Comprehensive income	$ 3,602	$ 3,022	$ 1,505

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

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2018	198,572	$ 33	$ 2,445	$ 13,670	$ 19	$ (6,325)	$ 9,842
Net income				1,683			1,683
Other comprehensive income				(4)	(178)		(182)
Common stock repurchases	—		50			(1,140)	(1,090)
Dividends and dividend equivalents			—	(277)			(277)
Stock-based compensation			137				137
Restricted stock unit vesting	—	—	(145)			145	—
Stock option exercises	23	—	48			—	48
Balances, December 31, 2018	198,595	33	2,535	15,072	(159)	(7,320)	10,161
Net income				2,707			2,707
Other comprehensive loss				—	315		315
Common stock repurchases	—		150			(1,220)	(1,070)
Dividends and dividend equivalents			—	(296)			(296)
Stock-based compensation			163				163
Restricted stock unit vesting	32	—	(48)			48	—
Stock option exercises	3	—	20			37	57
Balances, December 31, 2019	198,630	33	2,820	17,483	156	(8,455)	12,037
Net income				3,367			3,367
Impact of adopting accounting standard				(2)			(2)
Other comprehensive income				—	235		235
Common stock repurchases	—		(263)			(1,557)	(1,820)
Dividends and dividend equivalents			—	(331)			(331)
Stock-based compensation			181				181
Restricted stock unit vesting	19	—	(59)			59	—
Stock option exercises	—	—	26			35	61
Balances, December 31, 2020	198,649	$ 33	$ 2,705	$ 20,517	$ 391	$ (9,918)	$ 13,728

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

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW

	For the year ended December 31,		
	2020	**2019**	**2018**
	(in millions)		
Cash flows from operating activities			
Net income	$ 3,367	$ 2,707	$ 1,683
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss on sale of business	—	—	786
Gains on investment securities, net	(838)	(62)	(90)
Equity in net earnings	(74)	(14)	(11)
Stock compensation	181	163	137
Depreciation	528	505	444
Amortization	88	70	90
Provision for deferred income taxes	195	162	194
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(85)	(32)	(164)
Other assets	(581)	118	(484)
Benefits payable	2,139	1,142	252
Other liabilities	599	471	(676)
Unearned revenues	71	(36)	(95)
Other	49	90	107
Net cash provided by operating activities	5,639	5,284	2,173
Cash flows from investing activities			
Acquisitions, net of cash acquired	(709)	—	(354)
Purchase of equity method investment in Kindred at Home	—	—	(1,095)
Cash transferred in sale of business	—	—	(805)
Purchases of property and equipment	(964)	(736)	(612)
Purchases of investment securities	(9,125)	(6,361)	(4,687)
Maturities of investment securities	4,986	1,733	972
Proceeds from sales of investment securities	2,747	4,086	3,494
Net cash used in investing activities	(3,065)	(1,278)	(3,087)
Cash flows from financing activities			
Withdrawals from contract deposits, net	(939)	(623)	(640)
Proceeds from issuance of senior notes, net	1,088	987	—
Repayment of senior notes	(400)	(400)	—
Proceeds (repayments) from issuance of commercial paper, net	295	(360)	485
Proceeds from term loan	1,000	—	1,000
Repayment of term loan	(1,000)	(650)	(350)
Common stock repurchases	(1,820)	(1,070)	(1,090)
Dividends paid	(323)	(291)	(265)
Change in book overdraft	95	54	30
Proceeds from stock option exercises & other	49	58	45
Net cash used in financing activities	(1,955)	(2,295)	(785)
Increase (decrease) in cash and cash equivalents	619	1,711	(1,699)
Cash and cash equivalents at beginning of period	4,054	2,343	4,042
Cash and cash equivalents at end of period	$ 4,673	$ 4,054	$ 2,343

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW—(Continued)

	For the year ended December 31,		
	2020	**2019**	**2018**
		(in millions)	
Supplemental cash flow disclosures:			
Interest payments	$ 258	$ 212	$ 195
Income tax payments, net	$ 1,132	$ 518	$ 631
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 819	$ 28	$ 392
Less: Fair value of liabilities assumed	(110)	(28)	(38)
Cash paid for acquired businesses, net of cash acquired	$ 709	$ —	$ 354

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

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 83% of our total premiums and services revenue from contracts with the federal government in 2020, including 14% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

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

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

COVID-19

The emergence and spread of COVID-19 has impacted our business. Beginning in the second half of March 2020, the implementation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity resulted in the temporary deferral of non-essential care and significant reduction in hospital admissions and overall healthcare system utilization during April 2020. Non-COVID utilization then began to increase during May and June 2020, and continued to rebound throughout the third quarter and early in the fourth quarter of 2020, reaching approximately 95% of historic baseline levels as of the end of October 2020. Then, in the latter half of November and accelerating throughout the month of December, we experienced a significant increase in COVID-19 admissions in nearly all of the markets in which we operate across our Medicare Advantage, Medicaid, and group commercial insurance business lines, resulting in higher COVID-19 treatment and testing costs. During this period, we also experienced a corresponding decline in non-COVID utilization in all service categories to well below the near baseline levels of non-COVID utilization witnessed as late as the end of October 2020 (with non-COVID utilization in our Medicare Advantage business running approximately 15%

below normal levels at the close of the fourth quarter of 2020). The impact of this decline in non-COVID utilization more than offset the higher COVID-19 treatment and testing costs during this period. Our 2020 results were also impacted by our ongoing pandemic relief efforts and strategic investments in our integrated care delivery model.

Workforce Optimization

We initiated an involuntary workforce reduction program during 2019. This program impacted approximately 1,000 associates. As a result, we recorded charges of $47 million in 2019. Payments under this program were made upon termination during the severance pay period. The remaining 2019 workforce optimization obligation was $45 million as of December 31, 2019 and was fully settled as of December 31, 2020.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurance industry fee, but the fee resumed in calendar year 2020. The Further Consolidated Appropriations Act, 2020, enacted on December 20, 2019, permanently repealed the health insurance industry fee beginning in calendar year 2021.

The annual premium-based fee on health insurers is not deductible for tax purposes. We estimate a liability for the health insurance industry fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurance industry fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurance industry fee in September or October of each year. We paid the federal government $1.18 billion and $1.04 billion for the annual health insurance industry fee attributed to calendar years 2020 and 2018, respectively.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under Health Care Reform, for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, we received a $609 million payment from the U.S Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $609 million payment received from the U.S Government and approximately $31 million in related fees and expenses are reflected in Premiums revenue and Operating costs, respectively, in our consolidated statements of income for the year ended December 31, 2020 and reported in the Corporate segment.

Cash and Cash Equivalents

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

Investment Securities

Investment securities, which consist of debt and equity securities, are stated at fair value. Our debt securities have been categorized as available for sale. Debt securities available for current operations are classified as current assets and debt securities available to fund our professional and other self-insurance liability requirements, as well as restricted statutory deposits and equity securities, are classified as long-term assets. For the purpose of determining realized gross gains and losses for debt securities sold, which are included as a component of investment income in

the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses for debt securities, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or an expected credit loss is recognized. For the purpose of determining gross gains and losses for equity securities, changes in fair value at the reporting date are included as a component of investment income in the consolidated statements of income.

Prior to January 1, 2020, we applied the other-than-temporary impairment model for securities in an unrealized loss position which did not result in any material impairments for 2019 or 2018. Beginning on January 1, 2020, we adopted the new current expected credit losses, or CECL, model which retained many similarities from the previous other-than-temporary impairment model except eliminating from consideration in the impairment analysis the length of time over which the fair value had been less than cost. Also, under the CECL model, expected losses on available for sale debt securities are recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities. For debt securities whose fair value is less than their amortized cost which we do not intend to sell or are not required to sell, we evaluate the expected cash flows to be received as compared to amortized cost and determine if an expected credit loss has occurred. In the event of an expected credit loss, only the amount of the impairment associated with the expected credit loss is recognized in income with the remainder, if any, of the loss recognized in other comprehensive income. To the extent we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value.

Potential expected credit loss impairment is considered using a variety of factors, including the 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 debt security; changes in the quality of the debt security's credit enhancement; payment structure of the debt security; changes in credit rating of the debt security by the rating agencies; failure of the issuer to make scheduled principal or interest payments on the debt security and changes in prepayment speeds. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. We estimate the amount of the expected credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The expected credit loss cannot exceed the full difference between the amortized cost basis and the fair value.

Receivables and Revenue Recognition

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

Premiums Revenue

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium. Receivables or payables are classified as current or long-term in our consolidated balance sheet based on the timing of the expected settlement.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder

rebates by projecting calendar year minimum benefit ratios for the small group and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by Health and Human Services, or HHS, separately by state and legal entity. Medicare Advantage and Medicaid products are also subject to minimum benefit ratio requirements. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

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

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

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2020, subsidy and discount payments of $13.3 billion exceeded reimbursements of $12.4 billion by $0.9 billion. For 2019, subsidy and discount payments of $11.8 billion exceeded reimbursements of $11.2 billion by $0.6 billion. For 2018, subsidy and discount payments of $10.3 billion exceeded reimbursements of $9.6 billion by $0.7 billion. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 7 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

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

Administrative services fees

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

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

Our TRICARE members are served by both in-network and out-of-network providers in accordance with our contracts. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2020, health care cost reimbursements and payments were each approximately $6.3 billion with payments exceeding reimbursements by $1 million. For 2019, health care cost payments of approximately $6.5 billion exceeded reimbursements of approximately $6.4 billion by $63 million. For 2018, health care cost reimbursements and payments were each approximately $5.6 billion with reimbursements exceeding payments by $38 million for the year.

Receivables

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

At December 31, 2020 and 2019, accounts receivable related to services were $161 million and $141 million, respectively. For the year ended December 31, 2020, we had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the consolidated balance sheet at December 31, 2020 and 2019.

For the year ended December 31, 2020, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price), was not material. Further, revenue expected to be recognized in any future year related to remaining performance obligations was not material.

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 7, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates receivable was $1.4 billion and $1.3 billion at December 31, 2020 and 2019, respectively.

Policy Acquisition Costs

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

Long-Lived Assets

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

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

Equity Method Investments

We use the equity method of accounting for equity investments in companies where we are able to exercise significant influence, but not control, over operating and financial policies of the investee. Judgment regarding the level of influence over each equity method investment includes considering key factors such as our ownership interest, representation on the board of directors, organizational structure, participation in policy-making decisions and material intra-entity transactions.

Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by our share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies. Our proportionate share of the net income or loss of these companies is included in consolidated net income. Investment amounts in excess of our share of an investee's net assets are amortized over the life of the related asset creating the excess. Excess goodwill is not amortized.

We evaluate equity method investments for impairment whenever events or changes in circumstances indicate that the carrying amount of the investment might not be recoverable. Factors considered by us when reviewing an equity method investment for impairment include the length of time (duration) and the extent (severity) to which the fair value of the equity method investment has been less than carrying value, the investee's financial condition and near-term prospects and the intent and ability to hold the investment for a period of time sufficient to allow for anticipated recovery. An impairment that is other-than-temporary is recognized in the period identified.

See Note 4 for further information.

Goodwill and Definite-Lived Intangible Assets

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

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. However, unfavorable changes in key assumptions or combinations of assumptions including a significant increase in the discount rate, decrease in the long-term growth rate or substantial reduction in our underlying cash flow assumptions, including revenue growth rates, medical and operating cost trends, and projected operating income could have a significant negative impact on the estimated fair value of our clinical and provider reporting units, which accounted for $524 million and $761 million of goodwill, respectively. Impairment tests completed for 2020, 2019, and 2018 did not result in an impairment loss.

Definite-lived intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Definite-lived intangible assets are amortized over the useful life generally using the straight-line method. We review definite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

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

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

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

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent two months, a completion factor method uses historical paid claims patterns to estimate the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. Changes in claim inventory levels and known changes in claim payment processes are taken into account in these estimates. For the most recent two months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of hospital admissions, recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and workday seasonality.

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

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, public health emergencies, epidemics and pandemics (such as the spread of COVID-19) also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent two months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent two months. Each of these factors requires significant judgment by management.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise.

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

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies primarily related to certain blocks of insurance assumed in acquisitions, primarily life and annuities in run-off status, and are included in our consolidated balance sheet with other long-term liabilities. Prior period future policy benefits payable previously included as a separate line item has been reclassified to conform to the 2020 presentation. Most of these policies are subject to reinsurance as detailed in Note 19.

Book Overdraft

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

Income Taxes

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

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

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. We estimate expected forfeitures and recognize compensation expense only

for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model.

Additional detail regarding our stock-based compensation plans is included in Note 14.

Earnings Per Common Share

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

Additional detail regarding earnings per common share is included in Note 15.

Fair Value

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

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

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

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

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

Fair value of privately held debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows.

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In June 2016, the FASB issued guidance introducing a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The guidance was effective for us beginning January 1, 2020. The new current expected credit losses (CECL) model generally calls for the immediate recognition of all expected credit losses and applies to loans, accounts and trade receivables as well as other financial assets measured at amortized cost, loan commitments and off-balance sheet credit exposures, debt securities and other financial assets measured at fair value through other comprehensive income, and beneficial interests in securitized financial assets. The new guidance replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available for sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities, and provides for additional disclosure requirements. Our investment portfolio consists primarily of available for sale debt securities. We adopted the new standard effective January 1, 2020. Due to the high concentration of our financial assets measured at amortized cost being with the federal government resulting in zero nonpayment risk as well as our available for sale debt securities primarily being in an unrealized gain position, the adoption of the new standard did not have a material impact on our results of operations, financial condition, or cash flows.

Accounting Pronouncements Effective in Future Periods

In September 2018, the FASB issued new guidance related to accounting for long-duration contracts of insurers which revises key elements of the measurement models and disclosure requirements for long-duration contracts issued by insurers and reinsurers. The new guidance is effective for us beginning with annual and interim periods in 2023, with earlier adoption permitted, and requires retrospective application to previously issued annual and interim financial statements. We are currently evaluating the impact on our results of operations, financial position and cash flows.

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

3. ACQUISITIONS AND DIVESTITURES

Acquisitions

In the first quarter of 2020, we acquired privately held Enclara Healthcare, or Enclara, one of the nation’s largest hospice pharmacy and benefit management providers for cash consideration of approximately $709 million, net of cash received. This resulted in a purchase price allocation to goodwill of $517 million, other intangible assets of $240 million, and net tangible liabilities assumed of $13 million. The goodwill was assigned to the Healthcare Services segment. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 11 years. Enclara's goodwill is not amortizable as deductible expense for tax purposes.

Also in the first quarter of 2020, our Partners in Primary Care wholly-owned subsidiary entered into a strategic partnership with Welsh, Carson, Anderson & Stowe, or WCAS, to accelerate the expansion of our primary care model. The WCAS partnership opened 20 payor-agnostic, senior-focused primary care centers during 2020, and is expected to open an additional 30 over the next 2 years. Partners in Primary Care committed to the acquisition of a non-controlling interest in the approximately $600 million entity. In addition, the agreement includes a series of put

and call options through which WCAS may require us to purchase their interest in the entity and, through which we may acquire WCAS's interest over the next 5 to 10 years.

In the first quarter of 2018, we acquired the remaining equity interest in MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. The purchase price consisted primarily of $169 million cash, as well as our existing investment in MCCI and a note receivable and a revolving note with an aggregate balance of $383 million. This resulted in a purchase price allocation to goodwill of $483 million, other intangible assets of $80 million, and net tangible assets of $24 million. The goodwill was assigned to the Retail and Healthcare Services segments. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 8 years. Goodwill is amortizable as deductible expense for tax purposes.

In the second quarter of 2018, we acquired Family Physicians Group, or FPG, for cash consideration of approximately $185 million, net of cash received. FPG serves Medicare Advantage and Managed Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties. This resulted in a purchase price allocation to goodwill of $133 million, other intangible assets of $38 million and net tangible assets of $14 million. The goodwill was assigned to the Retail and Healthcare Services segments. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 5 years. The purchase price allocations for Enclara, MCCI and FPG are final.

During 2020 and 2019, we acquired other health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our consolidated statements of income and consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2020, 2019 and 2018 were not material to our results of operations. For asset acquisitions the goodwill acquired is partially amortizable as deductible expenses for tax purposes. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

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

On August 9, 2018, we completed the sale of KMG to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, included our closed block of non-strategic commercial long-term care policies. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. In connection with the sale of KMG, we recognized a pretax loss, including transaction costs, of $786 million and a corresponding $452 million tax benefit.

Prior to the sale of KMG, we entered into reinsurance contracts to transfer the risk associated with certain voluntary benefit and financial protection products previously issued primarily by KIC to a third party. We transferred approximately $245 million of cash to the third party and recorded a commensurate reinsurance recoverable as a result of these transactions. The reinsurance recoverable was included as part of the net assets disposed. There was no material impact to operating results from these reinsurance transactions.

KMG revenues and net income for the 2018 period prior to the date of sale were $182 million and $47 million, respectively.

4. EQUITY METHOD INVESTMENT

In the third quarter of 2018, we, along with TPG Capital, or TPG, and Welsh, Carson, Anderson & Stowe, or WCAS (together, the "Sponsors"), completed the acquisitions of Kindred Healthcare, Inc., or Kindred, and privately-held Curo Health Services, or Curo, respectively, merging Curo with the hospice business of the Kindred at Home Division, or Kindred at Home. As part of these transactions, we acquired a 40% minority interest in Kindred at Home, a leading home health and hospice company, for total cash consideration of approximately $1.1 billion.

We account for our 40% investment in Kindred at Home using the equity method of accounting. This investment is reflected in Equity method investments in our consolidated balance sheets, with our share of income or loss reported as Equity in net earnings in our consolidated statements of income.

We entered into a shareholders agreement with the Sponsors that provides for certain rights and obligations of each party. The shareholders agreement with the Sponsors includes a put option under which they have the right to require us to purchase their interest in the joint venture beginning on July 2, 2021 and ending on July 1, 2022. Likewise, we have a call option under which we have the right to require the Sponsors to sell their interest in the joint venture to Humana beginning on July 2, 2022 and ending on July 1, 2023. The put and call options, which are exercisable at a fixed EBITDA multiple and provide a minimum return on the Sponsor's investment if exercised, are measured at fair value each period using a Monte Carlo simulation. The simulation relies on assumptions around Kindred at Home's equity value, risk free interest rates, volatility, and the details specific to the put and call options. The fair values of the put option and call option were $45 million and $503 million, respectively, at December 31, 2020 and were $28 million and $557 million, respectively, at December 31, 2019.

The put option is included within other long-term liabilities and the call option is included within other long-term assets. The change in fair value of the put and call options for the years ended December 31, 2020 and 2019 of $71 million and $(506) million, respectively, are reported as Other expense (income), net in our consolidated statements of income.

The summarized balance sheets and statements of income at December 31, 2020 and 2019 of Kindred at Home were as follows:

Balance sheets	**December 31, 2020**	**December 31, 2019**
	(in millions)	
Current assets	$ 844	$ 563
Non-current assets	4,858	4,967
Current liabilities	556	405
Non-current liabilities	2,445	2,637
Shareholders' equity	2,700	2,488

Statements of income	**For the year ended December 31, 2020**	**For the year ended December 31, 2019**
	(in millions)	
Revenues	$ 2,972	$ 3,100
Expenses	2,552	2,835
Net income	207	54

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

5. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2020 and 2019, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2020				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 616	$ 1	$ (1)	$ 616
Mortgage-backed securities	3,115	140	(1)	3,254
Tax-exempt municipal securities	1,393	54	—	1,447
Mortgage-backed securities:				
Residential	17	—	—	17
Commercial	1,260	59	(1)	1,318
Asset-backed securities	1,364	10	(2)	1,372
Corporate debt securities	4,672	256	(1)	4,927
Total debt securities	$ 12,437	$ 520	$ (6)	12,951
Common stock				815
Total investment securities				$ 13,766
December 31, 2019				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 353	$ 1	$ —	$ 354
Mortgage-backed securities	3,628	85	(3)	3,710
Tax-exempt municipal securities	1,433	30	—	1,463
Commercial mortgage-backed securities	786	18	—	804
Asset-backed securities	1,093	3	(3)	1,093
Corporate debt securities	3,867	82	(2)	3,947
Total debt securities	$ 11,160	$ 219	$ (8)	11,371
Common stock				7
Total investment securities				$ 11,378

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

Gross unrealized losses and fair values aggregated by investment category and length of time that individual debt securities have been in a continuous unrealized loss position were as follows at December 31, 2020 and 2019, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2020						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 225	$ (1)	$ —	$ —	$ 225	$ (1)
Mortgage-backed securities	199	(1)	—	—	199	(1)
Tax-exempt municipal securities	16	—	19	—	35	—
Mortgage-backed securities:						
Residential	17	—	—	—	17	—
Commercial	193	(1)	43	—	236	(1)
Asset-backed securities	65	—	498	(2)	563	(2)
Corporate debt securities	342	(1)	16	—	358	(1)
Total debt securities	$ 1,057	$ (4)	$ 576	$ (2)	$ 1,633	$ (6)
December 31, 2019						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 48	$ —	$ 23	$ —	$ 71	$ —
Mortgage-backed securities	315	(1)	204	(2)	519	(3)
Tax-exempt municipal securities	58	—	75	—	133	—
Commercial mortgage-backed securities	118	—	36	—	154	—
Asset-backed securities	20	—	607	(3)	627	(3)
Corporate debt securities	589	(2)	155	—	744	(2)
Total debt securities	$ 1,148	$ (3)	$ 1,100	$ (5)	$ 2,248	$ (8)

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2020. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 1% of our total debt securities. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Our unrealized loss from all debt securities was generated from approximately 150 positions out of a total of approximately 1,520 positions at December 31, 2020. All issuers of debt securities we own that were trading at an unrealized loss at December 31, 2020 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2020, we did not intend to sell any debt securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these debt securities before recovery of their amortized

cost basis. Additionally, we did not record any material credit allowances for debt securities that were in an unrealized loss position at December 31, 2020.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2020, 2019, and 2018:

	2020	2019	2018
		(in millions)	
Gross gains on investment securities	$ 947	$ 129	$ 106
Gross losses on investment securities	(109)	(67)	(16)
Net realized gains on investment securities	$ 838	$ 62	$ 90

Gross gains and gross losses on investment securities include both the gain resulting from the initial conversion of our prior ownership interest in certain privately held companies into common stock upon such companies' initial public offering, or IPO, and subsequent changes in the market value of such securities from the IPO through December 31, 2020, which combined to total $837 million and $91 million, respectively.

All purchases of and proceeds from investment securities for the years ended December 31, 2020 and 2019 relate to debt securities.

There were no material other-than-temporary impairments in 2019 or 2018.

The contractual maturities of debt securities available for sale at December 31, 2020, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 802	$ 805
Due after one year through five years	2,145	2,236
Due after five years through ten years	2,247	2,396
Due after ten years	1,487	1,553
Mortgage and asset-backed securities	5,756	5,961
Total debt securities	$ 12,437	$ 12,951

6. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2020 and 2019, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2020				
Cash equivalents	$ 4,548	$ 4,548	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	616	—	616	—
Mortgage-backed securities	3,254	—	3,254	—
Tax-exempt municipal securities	1,447	—	1,447	—
Mortgage-backed securities:				
Residential	17	—	17	—
Commercial	1,318	—	1,318	—
Asset-backed securities	1,372	—	1,372	—
Corporate debt securities	4,927	—	4,927	—
Total debt securities	12,951	—	12,951	—
Common stock	815	815	—	—
Total invested assets	$ 18,314	$ 5,363	$ 12,951	$ —
December 31, 2019				
Cash equivalents	$ 3,660	$ 3,660	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	354	—	354	—
Mortgage-backed securities	3,710	—	3,710	—
Tax-exempt municipal securities	1,463	—	1,463	—
Mortgage-backed securities:				
Commercial	804	—	804	—
Asset-backed securities	1,093	—	1,093	—
Corporate debt securities	3,947	—	3,947	—
Total debt securities	11,371	—	11,371	—
Common stock	7	7	—	—
Total invested assets	$ 15,038	$ 3,667	$ 11,371	$ —

Financial Liabilities

Our debt is recorded at carrying value in our consolidated balance sheets. The carrying value of our senior notes debt outstanding, net of unamortized debt issuance costs, was $6,060 million at December 31, 2020 and $5,366 million at December 31, 2019. The fair value of our senior note debt was $7,352 million at December 31, 2020 and $5,916 million at December 31, 2019. The fair value of our senior note debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Due to the short-term nature, carrying value approximates fair value for commercial paper borrowings. The commercial paper borrowings were $600 million and $300 million at December 31, 2020 and December 31, 2019, respectively.

Put and Call Options Measured at Fair Value

The put and call options associated with our investment in Kindred at Home, which are exercisable at a fixed EBITDA multiple and provide a minimum return on the Sponsor's investment if exercised, are measured at fair value each period using a Monte Carlo simulation. The put and call options fair values, derived from the Monte Carlo simulation, were $45 million and $503 million, respectively, at December 31, 2020 and $28 million and $557 million, respectively, at December 31, 2019.

The significant unobservable inputs utilized in these Level 3 fair value measurements (and selected values) include the enterprise value of Kindred at Home, annualized volatility and secured credit rate. Enterprise value was derived from a discounted cash flow model, which utilized significant unobservable inputs for long-term net operating profit after tax margin, or NOPAT, to measure underlying cash flows, weighted average cost of capital and long term growth rate. The table below presents the assumptions used for each reporting period.

	December 31, 2020	December 31, 2019
Annualized volatility	29.9 %	19.8 %
Secured credit rate	0.4 %	2.2 %
NOPAT	12.0 %	12.0 %
Weighted average cost of capital	9.5 %	10.0 %
Long term growth rate	3.0 %	3.0 %

The calculation of NOPAT utilized net income plus after tax interest expense. We regularly evaluate each of the assumptions used in establishing these assets and liabilities. Significant changes in assumptions for weighted average cost of capital, long term growth rates, NOPAT, volatility, credit spreads, risk free rate, and underlying cash flow estimates, could result in significantly lower or higher fair value measurements. A change in one of these assumptions is not necessarily accompanied by a change in another assumption.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we acquired Enclara, MCCI, FPG, and other health and wellness related businesses during 2020, 2019, and 2018. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected future cash flows and discount rates used in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2020, 2019, or 2018.

7. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2020 and 2019. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2020		2019	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 216	$ 1,420	$ 5	$ 585
Trade accounts payable and accrued expenses	(39)	(253)	(120)	(356)
Net current asset (liability)	177	1,167	(115)	229
Other long-term assets	8	—	6	—
Other long-term liabilities	(90)	—	(61)	—
Net long-term liability	(82)	—	(55)	—
Total net asset (liability)	$ 95	$ 1,167	$ (170)	$ 229

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2020 and 2019.

	2020	2019
	(in millions)	
Land	$ 19	$ 20
Buildings and leasehold improvements	952	874
Equipment	1,009	922
Computer software	3,514	2,799
	5,494	4,615
Accumulated depreciation	(3,123)	(2,660)
Property and equipment, net	$ 2,371	$ 1,955

Depreciation expense was $528 million in 2020, $505 million in 2019, and $444 million in 2018, including amortization expense for capitalized internally developed and purchased software of $351 million in 2020, $343 million in 2019, and $298 million in 2018.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2020 and 2019 were as follows:

	Retail	Group and Specialty	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2019	$ 1,535	$ 261	$ 2,101	$ 3,897
Acquisitions	—	—	31	31
Balance at December 31, 2019	1,535	261	2,132	3,928
Acquisitions	—	—	519	519
Balance at December 31, 2020	$ 1,535	$ 261	$ 2,651	$ 4,447

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2020 and 2019.

	Weighted Average Life	2020			2019		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Customer contracts/relationships	9.5 years	$ 849	$ 572	$ 277	$ 646	$ 496	$ 150
Trade names and technology	7.0 years	122	89	33	84	84	—
Provider contracts	11.8 years	69	50	19	70	44	26
Noncompetes and other	7.3 years	29	29	—	29	28	1
Total other intangible assets	9.3 years	$ 1,069	$ 740	$ 329	$ 829	$ 652	$ 177

Amortization expense for other intangible assets was approximately $88 million in 2020, $70 million in 2019, and $90 million in 2018. Amortization expense for 2018 included $12 million associated with the write-off of a trade name value reflecting the re-branding of certain provider assets.

The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2021	$ 56
2022	53
2023	40
2024	33
2025	33

10. LEASES

We determine if a contract contains a lease by evaluating the nature and substance of the agreement. We lease facilities, computer hardware, and other furniture and equipment. Leases with an initial term of 12 months or less are not recorded on the balance sheet; we recognize lease expense for these leases on a straight-line basis over the lease term. For new lease agreements, we combine lease and nonlease components for all of our asset classes.

When portions of the lease payments are not fixed or depend on an index or rate, we consider those payments to be variable in nature. Our variable lease payments include, but are not limited to, common area maintenance, taxes and insurance which are not dependent upon an index or rate. Variable lease payments are recorded in the period in which the obligation for the payment is incurred. Most leases include options to renew, with renewal terms that can extend the lease term. The exercise of lease renewal options is at our sole discretion. Certain leases also include options to purchase the leased property. The depreciable life of assets and leasehold improvements are limited by the expected lease term, unless there is a transfer of title or purchase option reasonably certain of exercise. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

Right-of-use assets included within other long-term assets in our consolidated balance sheets were $437 million and $410 million at December 31, 2020 and 2019, respectively. Operating lease liabilities included within trade accounts payable and accrued expenses were $129 million and $116 million at December 31, 2020 and December 31, 2019, respectively. Additionally, operating lease liabilities included within other long-term liabilities were $355 million and $332 million at December 31, 2020 and December 31, 2019, respectively. The classification of our operating lease liabilities is based on the remaining lease term.

For the years ended December 31, 2020 and December 31, 2019, total fixed operating lease costs, excluding short-term lease costs, were $141 million and $154 million, respectively, and are included within operating costs in our consolidated statements of income. Short-term lease costs were not material for the years ended December 31, 2020 and December 31, 2019. In addition, for the years ended December 31, 2020 and December 31, 2019, total variable operating lease costs were $92 million and $82 million, respectively, and are included within operating costs in our consolidated statements of income.

We sublease facilities or partial facilities to third party tenants for space not used in our operations. For the years ended December 31, 2020 and December 31, 2019, sublease rental income was $36 million and $45 million, respectively, and is included within operating costs in our consolidated statements of income.

The weighted average remaining lease term is 5.2 years and 4.9 years with a weighted average discount rate of 3.7% and 4.1% at December 31, 2020 and December 31, 2019, respectively. For the year-ended December 31, 2020 and December 31, 2019, cash paid for amounts included in the measurement of lease liabilities included within our operating cash flows was $146 million and $151 million, respectively.

Maturity of Lease Liabilities	December 31, 2020 (in millions)
2021	$ 146
2022	129
2023	82
2024	59
2025	41
After 2025	87
Total lease payments	544
Less: Interest	60
Present value of lease liabilities	$ 484

As most of our leases do not provide an implicit rate, we use our incremental borrowing rate, as adjusted for collateralized borrowings, based on the information available at date of adoption or commencement date in determining the present value of lease payments.

For the year ended 2018, under prior lease disclosure requirements

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancellable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the year ended December 31, 2018:

	2018
	(in millions)
Rent expense	$ 167
Sublease rental income	(32)
Net rent expense	$ 135

11. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable was as follows for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(in millions)	
Balances at January 1	$ 6,004	$ 4,862	$ 4,668
Less: Reinsurance recoverables	(68)	(95)	(70)
Balances at January 1, net	5,936	4,767	4,598
Incurred related to:			
Current year	61,941	54,193	46,385
Prior years	(313)	(336)	(503)
Total incurred	61,628	53,857	45,882
Paid related to:			
Current year	(54,003)	(48,421)	(41,736)
Prior years	(5,418)	(4,267)	(3,977)
Total paid	(59,421)	(52,688)	(45,713)
Reinsurance recoverable	—	68	95
Balances at December 31	$ 8,143	$ 6,004	$ 4,862

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $313 million in 2020, $336 million in 2019, and $503 million in 2018. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2020, 2019, and 2018.

	(Favorable) Unfavorable Medical Claims Reserve Development		
	2020	2019	2018
Retail Segment	$ (266)	$ (386)	$ (398)
Group and Specialty Segment	(47)	50	(46)
Individual Commercial Segment	—	—	(57)
Other Businesses	—	—	(2)
Total	$ (313)	$ (336)	$ (503)

The medical claims reserve development for 2020, 2019, and 2018 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development is primarily attributed to our Medicare Advantage medical business.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our segments as of December 31, 2020, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2019 and 2018 is presented as supplementary information.

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

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

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(in millions)	
Balances at January 1	$ 5,363	$ 4,338	$ 3,963
Less: Reinsurance recoverables	(68)	(95)	(70)
Balances at January 1, net	5,295	4,243	3,893
Incurred related to:			
Current year	56,821	48,983	41,323
Prior years	(266)	(386)	(398)
Total incurred	56,555	48,597	40,925
Paid related to:			
Current year	(49,586)	(43,831)	(37,189)
Prior years	(4,836)	(3,714)	(3,386)
Total paid	(54,422)	(47,545)	(40,575)
Reinsurance recoverable	—	68	95
Balances at December 31	$ 7,428	$ 5,363	$ 4,338

At December 31, 2020, benefits payable for our Retail segment included IBNR of approximately $4.7 billion, primarily associated with claims incurred in 2020. The cumulative number of reported claims as of December 31, 2020 was approximately 133.0 million for claims incurred in 2020, 128.8 million for claims incurred in 2019, and 109.9 million for claims incurred in 2018.

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

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2020, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2018 Unaudited	2019 Unaudited	2020
	(in millions)		
2018	$ 41,323	$ 40,984	$ 40,946
2019		48,983	48,820
2020			56,821
Total			$ 146,587

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2018 Unaudited	2019 Unaudited	2020
	(in millions)		
2018	$ 37,189	$ 40,841	$ 40,946
2019		43,831	48,627
2020			49,586
Total			139,159
All outstanding benefit liabilities before 2018, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 7,428

Group and Specialty Segment

Activity in benefits payable for our Group and Specialty segment, excluding military services, was as follows for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(in millions)	
Balances at January 1	$ 641	$ 517	$ 568
Incurred related to:			
Current year	5,576	5,708	5,466
Prior years	(47)	50	(46)
Total incurred	5,529	5,758	5,420
Paid related to:			
Current year	(4,873)	(5,081)	(4,957)
Prior years	(582)	(553)	(514)
Total paid	(5,455)	(5,634)	(5,471)
Balances at December 31	$ 715	$ 641	$ 517

At December 31, 2020, benefits payable for our Group and Specialty segment included IBNR of approximately $594 million, primarily associated with claims incurred in 2020. The cumulative number of reported claims as of December 31, 2020 was approximately 8.6 million for claims incurred in 2020, 10.0 million for claims incurred in 2019, and 10.9 million for claims incurred in 2018.

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

The following tables provide information about incurred and paid claims development for the Group and Specialty segment as of December 31, 2020, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2018 Unaudited**	**2019 Unaudited**	**2020**
		(in millions)	
2018	$ 5,466	$ 5,501	$ 5,505
2019		5,708	5,657
2020			5,576
Total			$ 16,738

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2018 Unaudited**	**2019 Unaudited**	**2020**
		(in millions)	
2018	$ 4,957	$ 5,487	$ 5,505
2019		5,081	5,645
2020			4,873
Total			16,023
All outstanding benefit liabilities before 2018, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 715

Reconciliation to Consolidated

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

	December 31, 2020
Net outstanding liabilities	
Retail	$ 7,428
Group and Specialty	715
Benefits payable, net of reinsurance	8,143
Reinsurance recoverable on unpaid claims	
Retail	—
Total benefits payable, gross	$ 8,143

12. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(in millions)	
Current provision:			
Federal	$ 1,019	$ 560	$ 139
States and Puerto Rico	93	41	58
Total current provision	1,112	601	197
Deferred expense	195	162	194
Provision for income taxes	$ 1,307	$ 763	$ 391

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2020, 2019 and 2018 due to the following:

	2020	2019	2018
		(in millions)	
Income tax provision at federal statutory rate	$ 982	$ 729	$ 436
States, net of federal benefit, and Puerto Rico	63	49	42
Tax exempt investment income	(5)	(6)	(11)
Health insurance industry fee	268	—	243
Nondeductible executive compensation	19	25	17
Tax reform	—	—	(39)
KMG sale	—	—	(272)
Other, net	(20)	(34)	(25)
Provision for income taxes	$ 1,307	$ 763	$ 391

The tax reform law enacted on December 22, 2017, or Tax Reform Law, reduced the statutory federal corporate income tax rate to 21 percent from 35 percent, beginning in 2018, and required a mandatory deemed repatriation of undistributed foreign earnings. The rate reduction required a remeasurement of our net deferred tax asset. Revisions to our prior estimate for the income tax effects of the Tax Reform Law decreased our 2018 tax provision by approximately $39 million.

Due to a higher tax basis in KMG than book basis the incremental tax benefit on the sale of KMG of $272 million resulted from a tax loss higher than the loss recorded in the statement of income for the year ended December 31, 2018. In addition, the amount reflects our ability to carryback the capital loss to tax years 2015, 2016 and 2017 at the historical tax rate of 35 percent instead of the current tax rate of 21 percent.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled.

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

Principal components of our net deferred tax balances at December 31, 2020 and 2019 were as follows:

	Assets (Liabilities)	
	2020	2019
	(in millions)	
Compensation and other accrued expense	$ 171	$ 111
Benefits payable	87	89
Net operating loss carryforward	32	42
Deferred acquisition costs	26	22
Unearned revenues	12	8
Other	11	8
Capital loss carryforward	—	1
Total deferred income tax assets	339	281
Valuation allowance	(37)	(45)
Total deferred income tax assets, net of valuation allowance	302	236
Depreciable property and intangible assets	(449)	(329)
Investment securities	(418)	(181)
Prepaid expenses	(91)	(64)
Future policy benefits payable	(3)	(3)
Total deferred income tax liabilities	(961)	(577)
Total net deferred income tax liabilities	$ (659)	$ (341)

All deferred tax liabilities and assets are classified as noncurrent in our consolidated balance sheets as other long-term liabilities at December 31, 2020 and 2019.

At December 31, 2020, we had approximately $86 million of net operating losses to carry forward. These loss carryforwards, if not used to offset future taxable income, will expire from 2024 through 2031. Due to limitations and uncertainty regarding our ability to use some of the loss carryforwards and certain other deferred tax assets, a valuation allowance of $37 million was established. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to recover these deferred tax assets.

We file income tax returns in the United States and Puerto Rico. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2017 and prior years. Our 2018 and 2019 tax returns are in the post-filing review period under the Compliance Assurance Process, or CAP. Our 2020 tax return is under advance review by the IRS under CAP. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2017. We are not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

13. DEBT

The carrying value of debt outstanding was as follows at December 31, 2020 and 2019:

	2020	2019
	(in millions)	
Short-term debt:		
Commercial paper	$ 600	$ 300
Senior notes:		
$400 million, 2.50% due December 15, 2020	—	399
Total short-term debt	$ 600	$ 699
Long-term debt:		
Senior notes:		
$600 million, 3.15% due December 1, 2022	$ 598	$ 598
$400 million, 2.90% due December 15, 2022	398	397
$600 million, 3.85% due October 1, 2024	598	597
$600 million, 4.50% due April 1, 2025	595	—
$600 million, 3.95% due March 15, 2027	596	595
$500 million, 3.125% due August 15, 2029	495	495
$500 million, 4.875% due April 1, 2030	494	—
$250 million, 8.15% due June 15, 2038	262	262
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	739	739
$400 million, 4.80% due March 15, 2047	396	396
$500 million, 3.95% due August 15, 2049	493	492
Total long-term debt	$ 6,060	$ 4,967

Maturities of the short-term and long-term debt for the years ending December 31, are as follows:

For the years ending December 31,	(in millions)
2021	$ 600
2022	1,000
2023	—
2024	600
2025	600
Thereafter	3,900

Senior Notes

In December 2020, we repaid $400 million aggregate principal amount of our 2.5% senior notes due on their maturity date of December 15, 2020.

In March 2020, we issued $600 million of 4.500% senior notes due April 1, 2025 and $500 million of 4.875% senior notes due April 1, 2030. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid, were approximately $1,088 million as of December 31, 2020. We used the net proceeds for general corporate purposes.

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

Credit Agreement

Our 5-year, $2.0 billion unsecured revolving credit agreement expires May 2022. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. If drawn upon, the revolving credit would revert to using the alternative base rate once LIBOR is discontinued. The LIBOR spread, currently 110.0 basis points, varies depending on our credit ratings ranging from 91.0 to 150.0 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15.0 basis points, may fluctuate between 9.0 and 25.0 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive covenants and a financial covenant regarding maximum debt to capitalization of 50% as well as customary events of default. We are in compliance with this financial covenant, with an actual debt to capitalization of 33% as measured in accordance with the credit agreement as of December 31, 2020. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the credit agreement to a maximum of $2.5 billion, through a $500 million incremental loan facility.

At December 31, 2020, we had no borrowings and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2020, we had $2 billion of remaining borrowing capacity (which excludes the uncommitted $500 million incremental loan facility under the credit agreement), none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

Under our commercial paper program we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time not to exceed $2 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2020 was $600 million, with $600 million outstanding at December 31, 2020 compared to $300 million outstanding at December 31, 2019. The outstanding commercial paper at December 31, 2020 had a weighted average annual interest rate of 0.34%.

Term Note

In February 2020, we entered into a new $1 billion term loan commitment with a bank that matures 1 year after the first draw, subject to a 1 year extension. In March 2020, we made a draw on the entire term loan commitment of $1 billion. The facility fee, interest rate and financial covenants are consistent with those of our revolving credit agreement. The note was prepayable without penalty. We repaid the $1 billion outstanding balance in November 2020.

14. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $236 million in 2020, $221 million in 2019, and $197 million in 2018. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $410.27 on December 31, 2020, approximately 10% of the retirement and savings plan's assets were invested in our common stock, or approximately 1.5 million shares, representing approximately 1.2% of the shares outstanding as of December 31, 2020. At December 31, 2020, approximately 1.3 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. Awards generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

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

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2020, 2019, and 2018:

	2020	2019	2018
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 171	$ 152	$ 124
Stock options	10	11	13
Total stock-based compensation expense	181	163	137
Tax benefit recognized	(29)	(35)	(21)
Stock-based compensation expense, net of tax	$ 152	$ 128	$ 116

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $32 million in 2020, $25 million in 2019, and $49 million in 2018. There was no capitalized stock-based compensation expense during these years.

At December 31, 2020, there were 11.7 million shares reserved for stock award plans under the Humana Inc. 2011 Stock Incentive Plan, or 2011 Plan, and 15.9 million shares reserved for stock award plans under the Humana Inc. 2019 Stock Incentive Plan, or 2019 Plan. These reserved shares included giving effect to, under the 2011 Plan, 3.9 million shares of common stock available for future grants assuming all stock options were granted or 1.7 million shares available for future grants assuming all restricted stock were granted. These reserved shares included giving effect to, under the 2019 Plan, 14.4 million shares of common stock available for future grants assuming all stock options were granted or 4.3 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock grants also include performance-based conditions generally associated with return on invested capital and strategic membership growth. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $354.66 in 2020, $302.09 in 2019, and $276.62 in 2018. Activity for our restricted stock was as follows for the year ended December 31, 2020:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2019	976	$ 245.21
Granted	471	354.66
Vested	(486)	274.80
Forfeited	(50)	303.74
Nonvested restricted stock at December 31, 2020	911	$ 282.81

Approximately 33% of the nonvested restricted stock at December 31, 2020 included performance-based conditions.

The fair value of shares vested was $191 million during 2020, $141 million during 2019, and $298 million during 2018. Total compensation expense not yet recognized related to nonvested restricted stock was $175 million at December 31, 2020. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

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

The weighted-average fair value of each option granted during 2020, 2019, and 2018 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2020	2019	2018
Weighted-average fair value at grant date	$ 69.73	$ 68.53	$ 63.67
Expected option life (years)	4.0 years	4.1 years	4.1 years
Expected volatility	24.9 %	25.5 %	26.1 %
Risk-free interest rate at grant date	1.2 %	2.4 %	2.5 %
Dividend yield	0.7 %	0.7 %	0.7 %

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

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

Activity for our option plans was as follows for the year ended December 31, 2020:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2019	493	$ 250.46
Granted	111	350.79
Exercised	(276)	221.15
Forfeited	(5)	307.96
Options outstanding at December 31, 2020	323	$ 309.04
Options exercisable at December 31, 2020	100	$ 277.51

As of December 31, 2020, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $32 million, and a weighted-average remaining contractual term of 4.9 years. As of December 31, 2020, exercisable stock options had an aggregate intrinsic value of $13 million, and a weighted-average remaining contractual term of 3.8 years. The total intrinsic value of stock options exercised during 2020 was $51 million, compared with $43 million during 2019 and $43 million during 2018. Cash received from stock option exercises totaled $61 million in 2020, $58 million in 2019, and $50 million in 2018.

Total compensation expense not yet recognized related to nonvested options was $9 million at December 31, 2020. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years.

15. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
		(dollars in millions, except per common share results, number of shares/options in thousands)	
Net income available for common stockholders	$ 3,367	$ 2,707	$ 1,683
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	132,199	134,055	137,486
Dilutive effect of:			
Employee stock options	92	107	194
Restricted stock	721	565	723
Shares used to compute diluted earnings per common share	133,012	134,727	138,403
Basic earnings per common share	$ 25.47	$ 20.20	$ 12.24
Diluted earnings per common share	$ 25.31	$ 20.10	$ 12.16
Number of antidilutive stock options and restricted stock awards excluded from computation	238	478	223

16. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2018, 2019, and 2020 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2018	$1.90	$262
2019	$2.15	$289
2020	$2.43	$322

In November 2020, the Board declared a cash dividend of $0.625 per share that was paid on January 29, 2021 to stockholders of record on December 31, 2020, for an aggregate amount of $81 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2021, the Board declared a cash dividend of $0.70 per share payable on April 30, 2021 to stockholders of record on March 31, 2021.

Stock Repurchases

Our Board of Directors may authorize the purchase of our common shares. Under our share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing.

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans.

On December 21, 2017, we entered into an accelerated stock repurchase agreement, the December 2017 ASR, with Bank of America, N.A., or BofA, to repurchase $1.0 billion of our common stock as part of the $3.0 billion share repurchase program authorized on December 14, 2017. On December 22, 2017, we made a payment of $1.0 billion to BofA from available cash on hand and received an initial delivery of 3.28 million shares of our common stock from BofA based on the then current market price of Humana common stock. The payment to BofA was recorded as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 3.28 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by BofA pending final settlement of the December 2017 ASR. Upon settlement of the ASR on March 26, 2018, we received an additional 0.46 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the ASR Agreement, less a discount, of $267.55, bringing the total shares received under this program to 3.74 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by BofA from capital in excess of par value to treasury stock.

On November 28, 2018, we entered into an accelerated stock repurchase agreement, the November 2018 ASR, with Goldman Sachs to repurchase $750 million of our common stock as part of the $3.0 billion share repurchase program authorized by the Board of Directors on December 14, 2017. On November 29, 2018, we made a payment of $750 million to Goldman Sachs from available cash on hand and received an initial delivery of 1.94 million shares of our common stock from Goldman Sachs. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $600 million increase in treasury stock, which reflected the value of the initial 1.94 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the November 2018 ASR. Upon final settlement of the November 2018 ASR on February 28, 2019, we received an additional 0.6 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $295.15, bringing the total shares received under this program to 2.54 million. In addition, upon settlement we reclassified the $150 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock.

On July 30, 2019, the Board of Directors replaced a previous share repurchase authorization of up to $3 billion (of which approximately $1.03 billion remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on June 30, 2022.

On July 31, 2019, we entered into an accelerated stock repurchase agreement, the July 2019 ASR, with Citibank, N.A., or Citi, to repurchase $1 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on July 30, 2019. On August 2, 2019, we made a payment of $1 billion to Citi and received an initial delivery of 2.7 million shares of our common stock. We recorded the payment to Citi as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 2.7 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by Citi pending final settlement of the July 2019 ASR. Upon final settlement of the July 2019 ASR on December 26, 2019, we received an additional 0.7 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $296.19, bringing the total shares received under the July 2019 ASR to 3.4 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by Citi from capital in excess of par value to treasury stock.

On December 22, 2020, we entered into separate accelerated stock repurchase agreements, ("the December 2020 ASR Agreements"), with Citibank, N.A., or Citi, and JPMorgan Chase Bank, or JPM, to repurchase $1.75 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on July 30, 2019. On December 23, 2020, in accordance with the December 2020 ASR Agreements, we made a payment of $1.75 billion ($875 million to Citi and $875 million to JPM) and received an initial delivery of 3.8 million shares of our common stock (1.9 million shares each from Citi and JPM). We recorded the payments to Citi and JPM as a reduction to stockholders' equity, consisting of an $1.5 billion increase in treasury stock, which reflects the value of the initial 3.8 million shares received upon initial settlement, and a $262.5 million decrease in

capital in excess of par value, which reflects the value of stock held back by Citi and JPM pending final settlement of the December 2020 ASR Agreements. The final number of shares that we may receive, or be required to remit, under the December 2020 ASR Agreements, will be determined based on the daily volume-weighted average share price of our common stock over the term of the December 2020 ASR Agreements, less a discount and subject to adjustments pursuant to the terms and conditions of the December 2020 ASR Agreements. We expect final settlement under the December 2020 Agreements to occur during the second quarter of 2021. The December 2020 Agreements contain provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement of the agreement may be accelerated, extended, or terminated early by Citi, JPM or Humana as well as various acknowledgments and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our common stock from Citi and JPM or we may be required to make a payment. If we are obligated to make a payment, we may elect to satisfy such obligation in cash or shares of our common stock.

On February 18, 2021, the Board of Directors replaced the previous share repurchase authorization of up to $3 billion (of which approximately $250 million remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring as of February 18, 2024.

Excluding shares acquired in connection with employee stock plans, share repurchases were as follows during the years ended December 31, 2020, 2019 and 2018.

		2020		2019		2018	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
		(in millions)					
December 2017	3,000	—	$ —	—	$ —	3.07	$ 1,024
July 2019	3,000	3.80	1,750	3.40	1,000	—	—
Total repurchases		3.80	$ 1,750	3.40	$ 1,000	3.07	$ 1,024

In connection with employee stock plans, we acquired 0.2 million common shares for $70 million in 2020, 0.2 million common shares for $70 million in 2019, and 0.4 million common shares for $116 million in 2018.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurance subsidiaries had aggregate statutory capital and surplus of approximately $9.4 billion and $8.0 billion as of December 31, 2020 and 2019, respectively, which exceeded aggregate minimum regulatory requirements of $7.0 billion and $5.9 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2021 is approximately $1.4 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual

dividends that were paid to our parent company were approximately $1.3 billion in 2020, $1.8 billion in 2019, and $2.3 billion in 2018.

17. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $291 million in 2021, $250 million in 2022, $138 million in 2023, $77 million in 2024, and $51 million in 2025. Purchase obligations exclude agreements that are cancellable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2020, we were not involved in any SPE transactions.

Guarantees and Indemnifications

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

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

Government Contracts

Our Medicare products, which accounted for approximately 82% of our total premiums and services revenue for the year ended December 31, 2020, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2021, and all of our product offerings filed with CMS for 2021 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the

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

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

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

results of operations, financial position, or cash flows. We report the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We believe that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and have provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial position, or cash flows.

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

We believe that CMS's statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS's 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS's final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2020, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2020, primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract comprises 32 states and approximately six million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our state-based Medicaid business accounted for approximately 6% of our total premiums and services revenue for the year ended December 31, 2020. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Florida for Long Term Support Services (LTSS), and in Illinois for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program.

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

Legal Proceedings and Certain Regulatory Matters

As previously disclosed, the Civil Division of the United States Department of Justice provided us with an information request in December 2014, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned United States of America *ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by us in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by us under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. We take seriously our obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations since the transfer to the Western District of Kentucky. We have substantially completed discovery with the relator who has pursued the matter on behalf of the United States following its unsealing, and expect the Court to consider our motion for summary judgment.

Other Lawsuits and Regulatory Matters

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

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate and payment disputes, including disputes over reimbursement rates required by statute, disputes arising from competitive procurement process, general contractual matters, intellectual property matters, and challenges to subrogation practices. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the individual may continue to prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of nonperformance of contractual obligations to providers, members, and others, including

failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

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

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

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

18. SEGMENT INFORMATION

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable 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, the Chief Operating Decision Maker, to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes our military services business, primarily our TRICARE T2017 East 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, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our non-consolidating minority investment in Kindred at Home and the strategic partnership with WCAS to develop and operate senior-focused, payor-agnostic, primary care centers.

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

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

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $16.5 billion in 2020, $14.9 billion in 2019, and $13.4 billion in 2018. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $127 million in 2020, $117 million in 2019, and $129 million in 2018.

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

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, were approximately 83% for 2020, 82% for 2019 and 81% for 2018.

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

	Retail	Group and Specialty	Healthcare Services	Eliminations/ Corporate	Consolidated
			(in millions)		
2020					
External revenues					
Premiums:					
Individual Medicare Advantage	$ 51,697	$ —	$ —	$ —	$ 51,697
Group Medicare Advantage	7,774	—	—	—	7,774
Medicare stand-alone PDP	2,742	—	—	—	2,742
Total Medicare	62,213	—	—	—	62,213
Fully-insured	688	4,761	—	602	6,051
Specialty	—	1,699	—	—	1,699
Medicaid and other	4,223	—	—	—	4,223
Total premiums	67,124	6,460	—	602	74,186
Services revenue:					
Provider	—	—	435	—	435
ASO and other	19	780	—	—	799
Pharmacy	—	—	581	—	581
Total services revenue	19	780	1,016	—	1,815
Total external revenues	67,143	7,240	1,016	602	76,001
Intersegment revenues					
Services	—	29	19,491	(19,520)	—
Products	—	—	7,928	(7,928)	—
Total intersegment revenues	—	29	27,419	(27,448)	—
Investment income	155	16	13	970	1,154
Total revenues	67,298	7,285	28,448	(25,876)	77,155
Operating expenses:					
Benefits	56,537	5,529	—	(438)	61,628
Operating costs	7,402	1,818	27,395	(26,563)	10,052
Depreciation and amortization	342	81	183	(117)	489
Total operating expenses	64,281	7,428	27,578	(27,118)	72,169
Income (loss) from operations	3,017	(143)	870	1,242	4,986
Interest expense	—	—	—	283	283
Other expense, net	—	—	—	103	103
Income (loss) before income taxes and equity in net earnings	3,017	(143)	870	856	4,600
Equity in net earnings	—	—	74	—	74
Segment earnings (loss)	$ 3,017	$ (143)	$ 944	$ 856	$ 4,674

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

	Retail	Group and Specialty	Healthcare Services	Eliminations/ Corporate	Consolidated
			(in millions)		
2019					
External revenues					
Premiums:					
Individual Medicare Advantage	$ 43,128	$ —	$ —	$ —	$ 43,128
Group Medicare Advantage	6,475	—	—	—	6,475
Medicare stand-alone PDP	3,165	—	—	—	3,165
Total Medicare	52,768	—	—	—	52,768
Fully-insured	588	5,123	—	—	5,711
Specialty	—	1,571	—	—	1,571
Medicaid and other	2,898	—	—	—	2,898
Total premiums	56,254	6,694	—	—	62,948
Services revenue:					
Provider	—	—	446	—	446
ASO and other	17	790	—	—	807
Pharmacy	—	—	186	—	186
Total services revenue	17	790	632	—	1,439
Total external revenues	56,271	7,484	632	—	64,387
Intersegment revenues					
Services	—	18	18,255	(18,273)	—
Products	—	—	6,894	(6,894)	—
Total intersegment revenues	—	18	25,149	(25,167)	—
Investment income	195	23	2	281	501
Total revenues	56,466	7,525	25,783	(24,886)	64,888
Operating expenses:					
Benefits	48,602	5,758	—	(503)	53,857
Operating costs	5,306	1,651	24,852	(24,428)	7,381
Depreciation and amortization	323	88	156	(109)	458
Total operating expenses	54,231	7,497	25,008	(25,040)	61,696
Income from operations	2,235	28	775	154	3,192
Interest expense	—	—	—	242	242
Other income, net	—	—	—	(506)	(506)
Income before income taxes and equity in net earnings	2,235	28	775	418	3,456
Equity in net earnings	—	—	14	—	14
Segment earnings	$ 2,235	$ 28	$ 789	$ 418	$ 3,470

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

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2018							
External revenues							
Premiums:							
Individual Medicare Advantage	$ 35,656	$ —	$ —	$ —	$ —	$ —	$ 35,656
Group Medicare Advantage	6,103	—	—	—	—	—	6,103
Medicare stand-alone PDP	3,584	—	—	—	—	—	3,584
Total Medicare	45,343	—	—	—	—	—	45,343
Fully-insured	510	5,444	—	8	—	—	5,962
Specialty	—	1,359	—	—	—	—	1,359
Medicaid and other	2,255	—	—	—	22	—	2,277
Total premiums	48,108	6,803	—	8	22	—	54,941
Services revenue:							
Provider	—	—	404	—	—	—	404
ASO and other	11	835	—	—	4	—	850
Pharmacy	—	—	203	—	—	—	203
Total services revenue	11	835	607	—	4	—	1,457
Total external revenues	48,119	7,638	607	8	26	—	56,398
Intersegment revenues							
Services	—	18	16,840	—	—	(16,858)	—
Products	—	—	6,330	—	—	(6,330)	—
Total intersegment revenues	—	18	23,170	—	—	(23,188)	—
Investment income	136	23	34	—	110	211	514
Total revenues	48,255	7,679	23,811	8	136	(22,977)	56,912
Operating expenses:							
Benefits	40,925	5,420	—	(70)	77	(470)	45,882
Operating costs	5,327	1,810	22,905	4	6	(22,527)	7,525
Depreciation and amortization	270	88	163	—	—	(116)	405
Total operating expenses	46,522	7,318	23,068	(66)	83	(23,113)	53,812
Income from operations	1,733	361	743	74	53	136	3,100
Loss on sale of business	—	—	—	—	—	786	786
Interest expense	—	—	—	—	—	218	218
Other expense, net	—	—	—	—	—	33	33
Income (loss) before income taxes and equity in net earnings	1,733	361	743	74	53	(901)	2,063
Equity in net earnings	—	—	11	—	—	—	11
Segment earnings (loss)	$ 1,733	$ 361	$ 754	$ 74	$ 53	$ (901)	$ 2,074

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life and annuities in run-off status are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Reinsurance recoverables, included in other current and long-term assets, were $194 million at December 31, 2020 and $267 million at December 31, 2019. The amount of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately $193 million at December 31, 2020 and approximately $267 million at December 31, 2019. Premiums ceded were $29 million in 2020, $1 billion in 2019 and $976 million in 2018. Benefits ceded were $7 million in 2020, $881 million in 2019, and $980 million in 2018. Historical ceded premium and benefits reflect the activity associated with ceding all risk under a Medicaid contract to a third party reinsurer. The reinsurance agreement ceding all risk under the Medicaid contract was terminated effective January 1, 2020.

We evaluate the financial condition of our reinsurers on a regular basis. Protective Life Insurance Company with $171 million in reinsurance recoverables is well-known and well-established with a AM Best rating of A+ at December 31, 2020. The remaining reinsurance recoverables of $22 million are divided between 10 other reinsurers, with $3 million subject to funds withheld accounts or other financial guarantees supporting the repayment of these amounts.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Humana Inc. and its subsidiaries (the "Company") as of December 31, 2020 and 2019, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flow for each of the three years in the period ended December 31, 2020, including the related notes and financial statement schedules listed in the index appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail,

accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Incurred but not yet Reported Benefits Payable

As described in Notes 2 and 11 to the consolidated financial statements, the Company's incurred but not yet reported benefits payable (IBNR) was $5.3 billion as of December 31, 2020. Management develops its estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. As described by management, for the periods prior to the most recent two months, a completion factor method uses historical paid claims patterns to estimate the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. Changes in claim inventory levels and known changes in claim payment processes are taken into account in these estimates. For the most recent two months, IBNR is estimated primarily from a trend analysis based upon per member per month claims trends developed from historical experience in the preceding months, adjusted for known changes in estimates of hospital admissions, recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix and workday seasonality.

The principal considerations for our determination that performing procedures relating to the valuation of IBNR is a critical audit matter are the significant judgment by management when developing the estimate of IBNR, which in turn led to a high degree of auditor judgment, subjectivity and effort in performing procedures to evaluate the actuarial methodologies and significant assumptions related to completion factors, per member per month claims trends, and the potential for moderately adverse conditions. Also, the audit effort involved the use of professionals with specialized skill and knowledge to assist in evaluating the audit evidence obtained.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of IBNR, including controls over the actuarial methodologies and development of significant assumptions related to completion factors, per member per month claims trends, and the potential for moderately adverse conditions. These procedures also included, among others, the involvement of professionals with specialized skill and knowledge to assist in developing an independent estimate of IBNR. This independent estimate includes a range of reasonable outcomes, including outcomes under moderately adverse conditions, which are compared to management's estimate of IBNR. Developing the independent estimate involved developing independent completion factors and per member per month claims trends assumptions using management's data,

testing the completeness and accuracy of data provided by management, and evaluating the reasonableness of management's assumptions.

Goodwill Impairment Assessment - Provider and Clinical Reporting Units

As described in Notes 2 and 9 to the consolidated financial statements, the Company's consolidated goodwill balance was $4.4 billion as of December 31, 2020, and the goodwill associated with the Provider and Clinical Reporting Units was $761 million and $524 million, respectively. Management conducts an impairment test in the fourth quarter of each year and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. Management relies on a discounted cash flow analysis to determine fair value and uses discount rates that correspond to a market-based weighted-average cost of capital, and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in management's cash flow projections, including revenue growth rates, medical and operating cost trends, and projected operating income, are supported with management's long-range business plan and annual planning process.

The principal considerations for our determination that performing procedures relating to the goodwill impairment assessment of the Provider and Clinical Reporting Units is a critical audit matter are the significant judgment by management when developing the fair value estimate of the reporting units, which in turn led to a high degree of auditor judgment, subjectivity, and audit effort in performing procedures to evaluate management's cash flow projections, including significant assumptions related to the revenue and terminal growth rates, projected operating income, and the discount rate. Also, the audit effort involved the use of professionals with specialized skill and knowledge to assist in evaluating the audit evidence obtained.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's goodwill impairment assessment, including controls over the significant assumptions used in the valuation of the Provider and Clinical Reporting Units. These procedures also included, among others, testing management's process for developing the fair value estimate of the reporting units; evaluating the appropriateness of the discounted cash flow analysis; testing the completeness and accuracy of underlying data used in the analysis; and evaluating the reasonableness of the significant assumptions used by management related to the revenue and terminal growth rates and projected operating income, by considering the past performance of the reporting units and considering whether these assumptions were consistent with evidence obtained in other areas of the audit. Professionals with specialized skill and knowledge were used to assist in the evaluation of the appropriateness of the Company's discounted cash flow analysis and the reasonableness of the significant assumptions related to the terminal growth rates and the discount rate impacting the reporting units' future cash flows.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 18, 2021

We have served as the Company's auditor since 1968.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2020, we as the principal executive officer, the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2020. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2020, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2020 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on pages 121-123.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2020 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the caption "Proposal One: Election of Directors" in such Definitive Proxy Statement.

Executive Officers of the Registrant

A list of our executive officers and biographical information appears in Part I, Item 1 of this Form 10-K.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day (the "Code"). All employees and directors are required to annually affirm in writing their acceptance of the Code. The Code was adopted by our Board of Directors in June 2014, replacing a previous iteration, known as the Humana Inc. Principles of Business Ethics, as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Code is available on the Investor Relations section of our web site at www.humana.com, and any waiver of the application of the Code with respect to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on the Investor Relations section of our Internet web site at www.humana.com is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors, pursuant to our Corporate Governance Guidelines;
- the pre-approval process of non-audit services provided by our independent accountants;
- our By-laws and Certificate of Incorporation;
- our Majority Vote policy, pursuant to our By-laws;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;

- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the caption "Corporate Governance – Audit Committee" of such Definitive Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Definitive Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, and key employees. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2020 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	323,009	$ 309.044	$ 18,281,908	(2)(3)(4)
Equity compensation plans not approved by security holders	—	—	—	
Total	323,009	$ 309.044	$ 18,281,908	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 14.
(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) The Humana Inc. Amended and Restated Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 18, 2019. On May 1, 2019, 16 million shares were registered with the Securities and Exchange Commission on Form S-8.
(4) Of the number listed above, 5,996,605 (1,704,458 from the 2011 Plan and 4,292,148 from the Amended and Restated Plan) can be issued as restricted stock at December 31, 2020 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan and 3.35 stock options in the Amended and Restated Plan).

The information under the captions “Stock Ownership Information - Security Ownership of Certain Beneficial Owners of Company Common Stock” and “Stock Ownership Information - Security Ownership of Directors and Executive Officers” in our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the captions “Certain Transactions with Management and Others” and “Corporate Governance – Director Independence” of such Definitive Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 22, 2021 appearing under the caption “Audit Committee Report” of such Definitive Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Condensed Financial Information at December 31, 2020 and 2019 and for the years ended December 31, 2020, 2019 and 2018
Schedule II	Valuation and Qualifying Accounts for the years ended December 31, 2020, 2019 and 2018

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) Humana Inc. Amended and Restated By-Laws of Humana Inc., effective as of December 14, 2017 (incorporated herein by reference to Exhibit 3(b) to Humana Inc.'s Current Report on Form 8-K filed on December 14, 2017).

4(a) Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(b) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(c) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006, Req. No. 333-132878).

(d) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 13 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.

(e) Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(f) Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(g) Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(h)	Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(i)	Tenth Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017).
(j)	Eleventh Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017).
(k)	Thirteenth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017).
(l)	Fourteenth Supplemental Indenture, dated August 15, 2019, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on August 15, 2019).
(m)	Fifteenth Supplemental Indenture, dated August 15, 2019, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on August 15, 2019).
(n)	Sixteenth Supplemental Indenture, dated March 26, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K, filed March 27, 2020).
(o)	Seventeenth Supplemental Indenture, dated March 26, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K, filed March 27, 2020).
(p)	Description of Securities (incorporated herein by reference to Exhibit 4(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10(a)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(b)*†	Humana Inc. Executive Incentive Compensation Plan, as amended and restated January 1, 2020.
(c)*	Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999, File No. 001-05975).
(d)*	The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
(e)*	Humana Inc. Executive Severance Policy, effective as of March 1, 2019 (incorporated herein by reference to Exhibit 10(f) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(f)*	Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).
(g)*	Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 18, 2011).

(h)*	Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994, File No. 001-05975).
(i)*	Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).
(j)*	Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).
(k)*	Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.
(l)	Five-Year $2 Billion Amended and Restated Credit Agreement, dated as of May 22, 2017, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent and as CAF Loan Agent, Bank of America, N.A. as Syndication Agent, Citibank, N.A., PNC Bank, National Association, U.S. Bank National Association, and Wells Fargo Bank, National Association, as Documentation Agents, and J.P. Morgan Chase Bank, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Citigroup Global Markets, Inc., PNC Capital Markets LLC, U.S. Bank National Association, and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on May 22, 2017).
(m)	Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(n)	Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(o)	Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(p)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(q)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(r)	Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(s)	Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005, File No. 001-05975).
(t)*	Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).
(u)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(v)*	Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).

(w)*	Amendment No. 2, dated as of August 16, 2018, to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated as of February 27, 2014 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.s Current Report on Form 8-K, filed on August 20, 2018).
(x)*	Humana Inc. Change in Control Policy, effective March 1, 2019 (incorporated herein by reference to Exhibit 10(aa) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(y)	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 7, 2014).
(z)	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(aa)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(bb)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K filed on February 16, 2018).
(cc)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(ff) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(dd)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(gg) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(ee)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(hh) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(ff)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10(ii) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(gg)*	Humana Inc. Compensation Recoupment Policy, effective February 21, 2019 (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(hh)*	Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 18, 2019).
(ii)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(jj)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).

(kk)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(ll)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(mm)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(nn)*†	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (Non-Qualified Stock Options).
(oo)*†	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan.
(pp)*†	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan.
(qq)*†	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (without retirement provisions).
(rr)*†	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (with retirement provisions).
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).
31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.

101 The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in iXBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2020 and 2019; (ii) the Consolidated Statements of Income for the years ended December 31, 2020, 2019 and 2018; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2020, 2019 and 2018; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2020, 2019, and 2018; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2020, 2019 and 2018; and (vi) Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.

104 Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.

*Exhibits 10(a) through and including 10(k), and Exhibits 10(t) through and including 10(x), as well as Exhibits 10(z) through and including Exhibit 10(rr) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Exchange Act, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2020	2019
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 436	$ 1,006
Investment securities	336	355
Receivable from operating subsidiaries	1,187	1,248
Other current assets	763	778
Total current assets	2,722	3,387
Property and equipment, net	1,774	1,403
Investments in subsidiaries	17,005	14,763
Equity method investment in Kindred at Home	1,147	1,063
Long-term investment securities	836	32
Other long-term assets	686	746
Total assets	$ 24,170	$ 21,394
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 1,342	$ 1,975
Current portion of notes payable to operating subsidiaries	36	36
Book overdraft	120	40
Short-term debt	600	699
Other current liabilities	1,438	1,128
Total current liabilities	3,536	3,878
Long-term debt	6,060	4,967
Other long-term liabilities	846	512
Total liabilities	10,442	9,357
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,648,742 shares issued at December 31, 2020 and 198,629,992 shares issued at December 31, 2019	33	33
Capital in excess of par value	2,705	2,820
Retained earnings	20,517	17,483
Accumulated other comprehensive income (loss)	391	156
Treasury stock, at cost, 69,787,614 shares at December 31, 2020 and 66,524,771 shares at December 31, 2019	(9,918)	(8,455)
Total stockholders' equity	13,728	12,037
Total liabilities and stockholders' equity	$ 24,170	$ 21,394

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2020	2019	2018
	(in millions)		
Revenues:			
Management fees charged to operating subsidiaries	$ 2,216	$ 1,789	$ 1,666
Investment and other income, net	763	28	30
	2,979	1,817	1,696
Expenses:			
Operating costs	2,204	1,577	1,468
Depreciation	397	387	342
Interest	283	242	218
	2,884	2,206	2,028
Other expense (income), net	60	(506)	33
Loss on sale of business	—	—	782
Income (loss) before income taxes and equity in net earnings of subsidiaries	35	117	(1,147)
Provision (benefit) for income taxes	18	27	(542)
Income (loss) before equity in net earnings of subsidiaries	17	90	(605)
Equity in net earnings of subsidiaries	3,269	2,603	2,277
Equity in net earnings of Kindred at Home	81	14	11
Net income	$ 3,367	$ 2,707	$ 1,683

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2020	2019	2018
	(in millions)		
Net income	$ 3,367	$ 2,707	$ 1,683
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	393	450	(189)
Effect of income taxes	(89)	(105)	51
Total change in unrealized investment gains/losses, net of tax	304	345	(138)
Reclassification adjustment for net realized gains included in investment income	(90)	(34)	(53)
Effect of income taxes	20	8	17
Total reclassification adjustment, net of tax	(70)	(26)	(36)
Other comprehensive income (loss), net of tax	234	319	(174)
Comprehensive income (loss) attributable to our equity method investment in Kindred at Home	1	(4)	(4)
Comprehensive income	$ 3,602	$ 3,022	$ 1,505

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2020	2019	2018
		(in millions)	
Net cash provided by operating activities	$ 2,531	$ 3,529	$ 2,719
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(709)	—	(354)
Acquisitions, equity method investment in Kindred at Home	—	—	(1,095)
Capital contributions to operating subsidiaries	(538)	(423)	(697)
Purchases of investment securities	(460)	(204)	(145)
Proceeds from sale of investment securities	13	15	35
Maturities of investment securities	411	134	59
Purchases of property and equipment, net	(785)	(585)	(465)
Net cash used in investing activities	(2,068)	(1,063)	(2,662)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	1,088	987	—
Repayment of senior notes	(400)	(400)	—
Proceeds (repayments) from issuance of commercial paper, net	295	(360)	485
Proceeds from term loan	1,000	—	1,000
Repayment of term loan	(1,000)	(650)	(350)
Change in book overdraft	80	2	(3)
Common stock repurchases	(1,820)	(1,070)	(1,090)
Dividends paid	(323)	(291)	(265)
Proceeds from stock option exercises and other	47	57	48
Net cash used in financing activities	(1,033)	(1,725)	(175)
(Decrease) increase in cash and cash equivalents	(570)	741	(118)
Cash and cash equivalents at beginning of year	1,006	265	383
Cash and cash equivalents at end of year	$ 436	$ 1,006	$ 265

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $1.3 billion in 2020, $1.8 billion in 2019, and $2.3 billion in 2018.

Guarantee

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

3. REGULATORY REQUIREMENTS

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurance subsidiaries had aggregate statutory capital and surplus of approximately $9.4 billion and $8.0 billion as of December 31, 2020 and 2019, respectively, which exceeded aggregate minimum regulatory requirements of $7.0 billion and $5.9 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2021 is approximately $1.4 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $1.3 billion in 2020, $1.8 billion in 2019, and $2.3 billion in 2018.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Notes 3 and 4 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. During 2020, 2019 and 2018, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 13 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDERS' EQUITY

Refer to Note 16 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2020, 2019, and 2018
(in millions)

	Balance at Beginning of Period	Additions: Acquired/(Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2020	$ 69	$ —	$ 36	$ (1)	$ (32)	$ 72
2019	79	—	(1)	—	(9)	69
2018	96	—	36	(29)	(24)	79
Deferred tax asset valuation allowance:						
2020	(45)	—	8	—	—	(37)
2019	(54)	—	9	—	—	(45)
2018	(49)	—	(5)	—	—	(54)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE
Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

Date: February 18, 2021

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Chief Financial Officer (Principal Financial Officer)	February 18, 2021
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 18, 2021
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 18, 2021
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 18, 2021
/s/ FRANK BISIGNANO **Frank Bisignano**	Director	February 18, 2021
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 18, 2021
/s/ RAQUEL C. BONO, M.D. **Raquel C. Bono, M.D.**	Director	February 18, 2021
/s/ WAYNE A. I. FREDERICK, M.D. **Wayne A. I. Frederick, M.D.**	Director	February 18, 2021
/s/ JOHN W. GARRATT **John W. Garratt**	Director	February 18, 2021
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 18, 2021
/s/ KAREN W. KATZ **Karen W. Katz**	Director	February 18, 2021
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 18, 2021
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 18, 2021
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 18, 2021

HUMANA INC.
EXECUTIVE INCENTIVE COMPENSATION PLAN
As Amended and Restated January 1, 2020

I. OBJECTIVES.

The objectives of the Humana Inc. Executive Incentive Compensation Plan, as amended and restated (the "Plan") are to (i) link the compensation of selected executives to certain key performance targets; and (ii) reward them, when appropriate, for their efforts in achieving the performance targets of Humana Inc. (the "Company"), consistent with appropriate balance of risk and reward and appropriate governance and risk management practices aligned to the Company's short-term and long-term strategic plan.

II. ELIGIBILITY AND AWARDS.

A. Executives eligible to participate in this Plan ("Participants") will be limited to Section 16 officers of Humana Inc., as determined pursuant to Section 16 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Participation in the Plan will be approved by the Organization & Compensation Committee of the Board of Directors of the Company (the "Committee"). Each Participant shall be notified of his/her selection as a Participant.

B. Incentive compensation will be computed by measuring the Company's achievement of predetermined goals ("Performance Targets") established by the Committee in accordance with Internal Revenue Service regulations promulgated under Section 162(m) of the Internal Revenue Code as amended (the "Code"), to the extent applicable. Performance Targets may be expressed in terms of (i) earnings per share, (ii) share price, (iii) consolidated net income, (iv) pre-tax profits, (v) earnings or net earnings, (vi) return on equity or assets, (vii) sales, (viii) cash flow from operating activities, (ix) return on invested capital, (x) membership, (xi) other performance objectives as determined by the Committee, to the extent permitted under Section 162(m) of the Code (if applicable), or (xii) any combination of the foregoing. Performance Targets may be in respect of the performance of the Company, any of its Subsidiaries, any of its divisions or any combination thereof. Performance Targets may be absolute or relative (to prior performance of the Company or to the performance of one or more other entities or external indices) and may be expressed in terms of a progression within a specified range.

C. Incentive compensation for a fiscal year or other relevant period determined by the Committee ("Performance Period") shall be based on the Participant's base salary paid or accrued during such fiscal year exclusive of any bonus, equity compensation, or fringe benefits paid or accrued during such fiscal year ("Salary"). The Committee shall determine, subject to the limits in the Plan, the potential percentage of Salary which any Participant shall be eligible to receive as incentive compensation, which need not be the same for each Participant. The precise percentage earned shall be based upon a schedule of achievement of Performance Targets. Notwithstanding anything herein to the contrary, the maximum incentive compensation paid for any fiscal year to the CEO may not exceed Six Million Dollars ($6,000,000), or Three Million Dollars ($3,000,000) for any other Participant.

D. The Company's achievement of any relevant Performance Targets will be determined in accordance with generally accepted accounting principles. Any incentive compensation generated pursuant to incentive plans of the Company, including this Plan, shall be accrued and deducted as an expense in the appropriate fiscal year in determining the achievement of any Performance Targets.

E. Each Participant may receive an award ("Award") if the Performance Target(s) established by the Committee are attained in the applicable Performance Period. The applicable Performance Period and Performance Target(s) shall be determined by the Committee consistent with the terms of the Plan and, to the extent applicable, Section 162(m) of the Code. Notwithstanding the

fact that the Performance Target(s) have been attained, the Committee may pay an Award of less than the amount determined by the formula or standard established by the Committee or may pay no Award at all.

F. The specific Performance Target(s) must be established by the Committee in advance of the deadlines applicable under Section 162(m) of the Code, to the extent applicable, and while the performance relating to the Performance Target(s) remains substantially uncertain within the meaning of Section 162(m) of the Code. The Performance Target(s) with respect to any Performance Period may be established on a cumulative basis or in the alternative, and may be established on a stand-alone basis with respect to the Company or on a relative basis with respect to any peer companies or index selected by the Committee. At the time the Performance Target(s) are selected, the Committee shall provide, in terms of an objective formula or standard for each Participant, the method of computing the specific amount of Award payable to the Participant if the Performance Target(s) are attained. The objective formula or standard shall preclude the use of discretion to increase the amount of any Award earned pursuant to the terms of the Award.

G. If services as a Participant commence after the adoption of the Plan and the Performance Target(s) are established for a Performance Period, the Committee may grant an Award that is proportionately adjusted based on the period of actual service, and the amount of any Award paid to such Participant shall not exceed that proportionate amount of the applicable maximum individual Award allowable under the Plan.

H. Notwithstanding anything to the contrary set forth herein, the Performance Target(s) shall be adjusted to reflect the following events, subject to such event resulting in a change to the applicable Performance Target in excess of the aggregate threshold amount established by the Committee at the time of the granting of the applicable Award;: (A) the acquisition or disposition of a business, a merger, or a similar transaction, and the related integration costs including external costs such as legal, accounting and consulting fees and internal costs such as severance and benefits, contract cancellation costs, lease abandonment costs, overhead costs of integration including allocated wages and benefits and administrative costs in connection therewith; (B) the impact of securities issuances or repurchases in connection with an acquisition or disposition of a business, a merger, or a similar transaction, and related expenses including both direct and incremental costs incurred in connection therewith; (C) changes in accounting principles, tax laws, or other laws, provisions or regulations; (D) any litigation or regulatory investigations not in the ordinary course of business; (E) restructuring activity, including, but not limited to, reductions in force not in the ordinary course of business; (F) impact of exit or disposal activities, such as the close of blocks of business, market or product exits, asset sales or abandonments, contracts placed in run-off, related premium deficiency reserves or capital charges; and (G) any extraordinary, natural disaster, unusual and/or infrequent event, including, but not limited to those defined by SEC Regulation S-K Item 10(e), as appropriate for reporting as non-GAAP financial measures. For the avoidance of doubt, the Committee shall in all events retain the discretion to reduce (but not increase) any Award, regardless of the result of any adjustments described above.

I. To preserve the intended incentives and benefits of an Award based on a Performance Target, the Committee may determine at the time Performance Targets are established that certain adjustments shall apply to the objective formula or standard with respect to the applicable Performance Target to take into account, in whole or in part, in any manner specified by the Committee, any one or more of the following with respect to the Performance Period: (i) the gain, loss, income or expense resulting from changes in accounting principles that become effective during the Performance Period; (ii) the gain, loss, income or expense reported publicly by the Company with respect to the Performance Period that are extraordinary or unusual in nature or infrequent in occurrence; (iii) the gains or losses resulting from, and the direct expenses incurred in connection with the disposition of a business, or the sale of investments or non-core assets; (iv) the gain or loss from all or certain claims and/or litigation and all or certain insurance

recoveries relating to claims or litigation; (v) the impact of impairment of tangible or intangible assets; including goodwill; (vi) the impact of restructuring or business recharacterization activities, including but not limited to reductions in force, that are reported publicly by the Company; or (vii) the impact of investments or acquisitions made during the year or, to the extent provided by the Committee, any prior year. Each of the adjustments described in this Section may relate to the Company as a whole or any part of the Company's business operations. The adjustments are to be determined in accordance with generally accepted accounting principles and standards, unless another objective method of measurement is designated by the Committee. In addition to the foregoing, the Committee shall adjust any Performance Targets or other features of an Award that relate to or are wholly or partially based on the number of, or the value of, any stock of the Company, to reflect any stock dividend or split, recapitalization, combination or exchange of shares or other similar changes in such stock.

J. The Committee has the sole discretion to determine the standard or formula pursuant to which each Participant's Award shall be calculated and whether all or any portion of the amount so calculated will be paid, subject in all cases to the terms, conditions and limits of the Plan. To this same extent, the Committee may at any time establish (and, once established, rescind, waive or amend) additional conditions and terms of payment of Awards (including but not limited to the achievement of other financial, strategic or individual goals, which may be objective or subjective) as it may deem desirable in carrying out the purposes of the Plan and may take into account such other factors as it deems appropriate in administering any aspect of the Plan. The Committee may not, however, increase the maximum amount permitted to be paid to any individual under the Plan or pay Awards under this Plan if applicable Performance Target(s) have not been satisfied.

K. Incentive compensation shall be paid to Participants on or before March 15th of the year following the fiscal year with respect to which it was earned or such earlier date as may be required in order that such amount be deductible under the Code for the fiscal year with respect to which it was earned.

III. ADMINISTRATION OF THIS PLAN.

The Committee has sole authority (except as specified otherwise herein) to determine all questions of interpretation and application of the Plan, or of the terms and conditions pursuant to which Awards are granted under the Plan and in general, to make all determinations advisable for the administration of the Plan to achieve its purpose. The Committee determinations under the Plan (including without limitation, determinations of the persons to receive Awards, the form, amount and timing of such Awards, the terms and provisions of such Awards and any agreements evidencing such Awards) need not be uniform and may be made by the Committee selectively among persons who receive or are eligible to receive Awards under the Plan, whether or not such persons are similarly situated. Such determinations shall be final and not subject to further appeal.

IV. TERMINATION OF EMPLOYMENT.

Subject to the discretion of the Committee, a Participant must be actively employed or on short-term disability (as determined pursuant to the applicable Company policy) on the last day of the applicable Performance Period to be eligible for a payout, unless the Participant's employment was terminated due to: (i) the Participant's death or [Disability (as defined in the Amended and Restated Humana Inc. Stock Incentive Plan)]; (ii) the Participant's Retirement; or (iii) the Participant's termination of employment due to a (A) Workforce Reduction, (B) Position Elimination, (C) Divestiture or (D) position reassignment to a Strategic Joint Venture (as each term is defined in the Amended and Restated Humana Inc. Stock Incentive Plan). To the extent that a Participant is not actively employed on the last day of the applicable Performance Period due to death, Disability, Retirement, Workforce Reduction, Position Elimination, Divestiture or position reassignment to a Strategic Joint Venture, the Participant will be eligible to receive a pro-rated Award based on the period that the Participant was actively employed during the Performance Period, with the amount of the pro-rated Award to be based on actual

performance and paid at the same time as Awards are paid to employees who remain actively employed through the end of the applicable Performance Period.

V. AMENDMENT OF PLAN.

Subject to any restrictions imposed under Section 162(m) of the Code, to the extent applicable, the Committee may at any time and from time to time alter, amend, suspend or terminate the Plan in whole or in part, provided that no such amendment that would require the consent of the Board and/or stockholders of the Company pursuant to Section 162(m) of the Code, to the extent applicable, or the Exchange Act, any New York Stock Exchange (or other relevant stock exchange) rule or regulation, or any other applicable law, rule or regulation, shall be effective without such consent.

VI. GENERAL PROVISIONS.

A. No person has any claim or right to be included in this Plan or to be granted incentive compensation under this Plan until such individual has been declared a Participant and received official notice thereof in accordance with the procedures as set forth in this Plan. In addition, all of the requirements and applicable rules and regulations of this Plan must have been met including, but not limited to the availability of funds for incentive compensation awards and the determination by the Committee of the extent to which Performance Targets have been met.

B. The designation of an individual as a Participant under this Plan does not in any way alter the nature of the Participant's employment relationship. Participation in this Plan shall not constitute a contract of employment between the Company or any subsidiary and any person and shall not be deemed to be consideration for, or a condition of, continued employment of any person.

C. No benefit provided under the Plan shall be subject to alienation or assignment by a Participant (or by any person entitled to such benefit pursuant to the terms of this Plan), nor shall it be subject to attachment or other legal process except (i) to the extent specifically mandated and directed by applicable state or federal statute; and (ii) as requested by the Participant and approved by the Committee to members of the Participant's family, or a trust established by the Participant for the benefit of family members.

D. The Company or a subsidiary may withhold any applicable federal, state or local taxes at such time and upon such terms and conditions as required by law or determined by the Company or subsidiary.

E. Each member of the Committee (and each person to whom the Committee or any member thereof has delegated any of its authority or power under this Plan) shall be fully justified in relying or acting in good faith upon any report made by the independent public accountants of the Company and its subsidiaries and upon any other information furnished the Committee in connection with the Plan. In no event shall any person who is or shall have been a member of the Committee be liable for any determination made or other action taken or any omission to act in reliance upon any such report or information, or for any action taken or failure to act if in good faith.

F. In the event the Company becomes a party to a merger, consolidation, sale of substantially all of its assets or any other corporate reorganization in which the Company will not be the surviving corporation or in which the holders of the common stock of the Company will receive securities of another corporation (in any such case, the "New Company"), then the New Company shall assume the rights and obligations of the Company under this Plan. All matters relating to the Plan or to G. Awards granted hereunder shall be governed by the laws of the State of Delaware, without regard to the principles of conflict of laws.

G. The expenses of administering the Plan shall be borne by the Company and its subsidiaries.

H. The titles and headings of the sections in the Plan are for convenience of reference only, and in the event of any conflict, the text of the Plan, rather than such titles or headings, shall control.

VII. STOCKHOLDER APPROVAL.

This Plan has been previously approved by the Company's stockholders at the April 24, 2008 annual meeting of stockholders.

VIII. INTERNAL REVENUE CODE SECTION 162(m).

Transactions under this Plan are intended to comply with all applicable conditions of Section 162(m) of the Internal Revenue Code, as amended, or its successor. To the extent any provision of the Plan or action by the Committee fails to so comply (to the extent applicable), it shall be deemed null and void, to the extent permitted by law and deemed advisable by the Committee.

VIII. INTERNAL REVENUE CODE SECTION 409A.

All Awards granted under the Plan are intended to be exempt from Section 409A of the Code. Notwithstanding this or any other provision of the Plan to the contrary, the Committee may amend the Plan or any Award granted hereunder in any manner, or take any other action that it determines, in its sole discretion, is necessary, appropriate or advisable (including replacing any Award) to cause the Plan or any Award granted hereunder to not be subject to Section 409A of the Code. Any such action, once taken, shall be deemed to be effective from the earliest date necessary to avoid a violation of Section 409A of the Code and shall be final, binding and conclusive on all Participants and other individuals having or claiming any right or interest under the Plan.

Adopted: August 21, 2019

HUMANA INC.
STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of <award_date> (the **"Date of Grant"**) by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to grant to Optionee an option to purchase shares of common stock of the Company in accordance with the Plan;

NOW, THEREFORE, in consideration of the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

I. OPTION GRANT

A. Grant of Option. The Company hereby grants to Optionee, as a matter of separate inducement and agreement and not in lieu of salary or other compensation for services, a Non-Qualified Stock Option to purchase <shares_awarded> shares of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of <award_price> per share (the **"Option"**) exercisable on the terms and conditions set forth herein.

B. Term. The term of the Option shall commence upon the Date of Grant, and shall expire on <expire_Date>.

C. Vesting of Option. Except as otherwise set forth herein, the Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the Date of Grant in cumulative annual installments of one-third of the number of Shares covered hereby.

D. Effect of Termination of Employment on Option. If the employment of Optionee by the Company is terminated for Cause, all the rights of Optionee under this Agreement, whether or not exercisable, shall terminate immediately. If the employment of Optionee is terminated for any reason other than for Cause, the Option shall vest and remain exercisable in accordance with Sections 12 and 13 of the Plan.

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E. Exercise of Option.

1. The Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the online procedure to such broker-dealer as designated by the Company, Optionee or his/her legal representative as herein provided. Such notice shall state the number of Shares with respect to which the Option is being exercised and shall be signed, or authorized electronically, by Optionee or his/her legal representative, as applicable.

2. The purchase price shall be paid as follows: (a) In full in cash upon the exercise of the Option; (b) By tendering to the Company Shares owned by Optionee prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to the Option; (c) A combination of I(E)(2)(a) and I(E)(2)(b) above; or (d) Through the cashless exercise provisions of the designated broker-dealer as described in the procedures communicated to Optionee by the Company.

3. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company (**"Withholding Taxes"**) in connection with the exercise of the Option shall be paid pursuant to the Plan by Optionee prior to the delivery of any Common Stock under this Agreement. The Company shall, at Optionee's election, withhold delivery of a number of Shares with a Fair Market Value as of the exercise date equal to the Withholding Taxes in satisfaction of Optionee's obligations hereunder.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Optionee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Optionee) that it is providing Optionee, and in the significant time, money, training, team building and other efforts it expends to develop Optionee's skills to assist in performing Optionee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Optionee agrees are valuable assets of the Company to which it has devoted substantial resources. Optionee acknowledges that the grant Optionee is receiving under the Plan is a meaningful way that the Company entrusts Optionee with its goodwill and aligns Optionee with the Company objective of increasing the value of the Company's business. Accordingly, Optionee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Optionee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Optionee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Optionee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Optionee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Optionee that are satisfactory to the Company that Optionee, during the Restricted Period, will not work on or provide Competitive Products or Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Optionee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Optionee is or will be in violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Optionee commences employment for the Competitor. Such "Written Assurances" shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Optionee from investing Optionee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Optionee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Optionee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Optionee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Optionee worked, had business contact, or about which Optionee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4)

provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Optionee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Options, the prohibitions on Optionee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Optionee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Options, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Optionee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Optionee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Optionee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Options that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Options as a result of Optionee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Options, assuming target performance has been achieved (or by the number of Shares underlying the Options that become vested as a result of the acceleration of vesting, if any), by the per Share Fair Market Value on the Last Day, divided by (B) Optionee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Optionee, in its discretion.

3. In the event Optionee is discharged by the Company other than with Cause prior to vesting herein of the Options, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Options, the prohibitions on Optionee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Optionee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Optionee the Non-Compete Payment. Notwithstanding any previous agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II(A), the "Non-Compete Payment" shall be an amount at least equal to Optionee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Optionee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Optionee and the Company, (ii) any agreement between Optionee and the Company not related to the employment of Optionee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Optionee set forth in Sections II(B) and II(C) shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Optionee shall forfeit all or a portion of any vested or unvested Options held by Optionee without payment and/or be required to repay or otherwise reimburse the Company for the gain or value realized in respect of all or a portion of any exercised Options.

1. If Optionee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Optionee shall immediately forfeit as of the date that the violation first occurs all unexercised Options described above in Section I(A) (whether vested or unvested) without payment. This provision does not alter the circumstances for forfeiture of unexercised Options as described in Section I(D) of this Agreement.

2. If Optionee has exercised any of the Options prior to the Forfeiture Event, then for any Option that has been exercised during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Optionee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to the amount described below.

To the extent that (i) any Shares related to exercised Options have been sold or transferred, the amount shall be the aggregate gross proceeds realized by Optionee from such sale or transfer of the net Shares acquired after payment of the exercise price and any applicable taxes (the **"Net Shares"**) (or, in the case of any disposition or transfer of the Net Shares for less than the Fair Market Value of such Net Shares,

Optionee will repay or reimburse to the Company an amount equal to the Fair Market Value of such Net Shares) or (ii) if the Net Shares have not been sold at the time Company demand is made, the amount shall be the aggregate Fair Market Value of the Net Shares on the date the Options were exercised.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Optionee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Optionee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Options. By receiving the Options, Optionee agrees upon Optionee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes Optionee following the Last Day any amounts Optionee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Optionee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Optionee realizes any amounts in excess of what he or she should have received under the terms of any Options for any reason due to mistake in calculations or other administrative error, then Optionee shall be required to repay or reimburse any such excess amounts to the Company within thirty (30) days following the Company's written demand for repayment.

G. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to Kentucky's conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. Injunctive Relief; Invalidity of Any Provision. Optionee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Optionee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Optionee's unfair competition or

wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Optionee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Optionee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

I. Notice of Agreement. Optionee agrees that, during the Restricted Period, Optionee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Optionee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Optionee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. Tolling. In the event Optionee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Optionee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Optionee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Optionee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Optionee and all rights granted to Optionee and to the Company shall be binding upon Optionee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. Jurisdiction; Service of Process. Any action or proceeding seeking to enforce any provision of, or based on any right arising out of, this Agreement may be brought against any of the parties in the courts of the Commonwealth of Kentucky, County of Jefferson, or, if it has or can acquire jurisdiction, in the United States District Court for the Western District of Kentucky, and each of the parties consents to the jurisdiction of such courts (and of the appropriate appellate courts) in any such action or proceeding and waives any objection to venue laid therein. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere in the world.

E. No Employment Agreement. Nothing herein confers on Optionee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Optionee's employment or other service at any time.

F. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect. Any provision in this Agreement determined by competent authority to be in conflict with 422 of the Internal Revenue Code of 1986, as amended, or its successor, in regard to qualifying this Option as an incentive stock option shall be ineffective ab initio to the extent of such conflict.

G. Assignment. The Option granted under this Agreement to Optionee may not be assigned, transferred, pledged, alienated or hypothecated in any manner during Optionee's lifetime, but shall be solely and exclusively the right of Optionee to exercise during his/her lifetime. Should Optionee attempt to assign, transfer, pledge, alienate or hypothecate the Option or any rights hereunder in any manner whatsoever, such action shall constitute a breach of the covenants hereunder and the Company may terminate the Option as to any then unexercised shares.

H. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this

Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Optionee and any person or persons claiming through Optionee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) **"Change in Control Termination"** means, in the event the Option is assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Optionee is terminated within two (2) years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Optionee with Good Reason.

(ii) **"Competitive Product or Service"** means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Optionee worked or for which Optionee had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Optionee's Last Day (as defined below).

(iii) **"Competitor"** means Optionee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) **"Last Day"** means Optionee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Optionee's separation.

(v) **"Protected Relationship"** means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, long-term care facilities, state Medicaid agencies, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, customers, and/or sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Optionee, directly or indirectly (*e.g.*, through employees whom Optionee supervised) had material business contact and/or about whom Optionee obtained confidential information and trade secrets.

(vi) **"Restricted Geographic Area"** means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) c ity(ies)) in which, during the twenty-four (24) months prior to the Last Day, Optionee provided material services on behalf of the Company (or in which Optionee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) **"Restricted Period"** means the period of Optionee's employment with the Company, its subsidiaries', and/or its affiliates' and a period of twelve (12) months after the Last Day. Optionee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) "**Solicit**" means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Optionee or indirectly through another individual.

I. Execution. If Optionee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Optionee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

HUMANA INC.

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Optionee"

_____
<first_name> <middle_name> <last_name>

HUMANA INC.
INCENTIVE STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to grant to Optionee an option to purchase shares of common stock of the Company in accordance with the Plan;

NOW, THEREFORE, in consideration of the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

I. OPTION GRANT

A. Grant of Option. The Company hereby grants to Optionee, as a matter of separate inducement and agreement and not in lieu of salary or other compensation for services, an Incentive Stock Option to purchase <shares_awarded> shares of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of $<award_price> per share (the "**Option**") exercisable on the terms and conditions set forth herein.

B. Term. The term of the Option shall commence upon the Date of Grant, and shall expire on <expire_Date> (the **"Expiration Date"**).

C. Vesting of Option. Except as otherwise set forth herein, the Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the Date of Grant in cumulative annual installments of one-third of the number of Shares covered hereby.

D. Effect of Termination of Employment on Option. If the employment of Optionee by the Company is terminated for Cause, all the rights of Optionee under this Agreement, whether or not exercisable, shall terminate immediately. If the employment of Optionee is terminated for any reason other than for Cause, the Option shall vest and remain exercisable in accordance with Sections 12 and 13 of the Plan, but in no event beyond the Expiration Date.

E. Exercise of Option.

1. The Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the online procedure to such broker-dealer as designated by the Company, Optionee or his/her legal representative as herein provided. Such notice shall state the number of Shares with respect to which the Option is being exercised and shall be signed, or authorized electronically, by Optionee or his/her legal representative, as applicable.

2. The purchase price shall be paid as follows: (i) In full in cash upon the exercise of the Option; (ii) By tendering to the Company Shares owned by Optionee prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to the Option; or (iii) A combination of I(E)(2)(i) and I(E)(2)(ii) above.

3. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company (**"Withholding Taxes"**) in connection with the exercise of the Option shall be paid pursuant to the Plan by Optionee prior to the delivery of any Common Stock under this Agreement. The Company shall, at Optionee's election, withhold delivery of a number of Shares with a Fair Market Value as of the exercise date equal to the Withholding Taxes in satisfaction of Optionee's obligations hereunder.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Optionee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Optionee) that it is providing Optionee, and in the significant time, money, training, team building and other efforts it expends to develop Optionee's skills to assist in performing Optionee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Optionee agrees are valuable assets of the Company to which it has devoted substantial resources. Optionee acknowledges that the grant Optionee is receiving under the Plan is a meaningful way that the Company entrusts Optionee with its goodwill and aligns Optionee with the Company objective of increasing the value of the Company's business. Accordingly, Optionee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Optionee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Optionee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Optionee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Optionee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Optionee that are satisfactory to the Company that Optionee, during the Restricted Period, will not work on or provide Competitive Products or Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Optionee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Optionee is or will be in violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Optionee commences employment for the Competitor. Such "Written Assurances" shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Optionee from investing Optionee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Optionee's holdings

represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Optionee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Optionee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Optionee worked, had business contact, or about which Optionee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Optionee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Options, the prohibitions on Optionee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Optionee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Options, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Optionee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Optionee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Optionee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Options that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Options as a result of Optionee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Options, assuming target performance has been achieved (or by the number of Shares underlying the Options that become vested as a result of the acceleration of vesting,

if any), by the per Share Fair Market Value on the Last Day, divided by (B) Optionee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Optionee, in its discretion.

3. In the event Optionee is discharged by the Company other than with Cause prior to vesting herein of the Options, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Options, the prohibitions on Optionee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Optionee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Optionee the Non-Compete Payment. Notwithstanding any previous agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II(A), the "Non-Compete Payment" shall be an amount at least equal to Optionee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Optionee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Optionee and the Company, (ii) any agreement between Optionee and the Company not related to the employment of Optionee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Optionee set forth in Sections II(B) and II(C) shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Optionee shall forfeit all or a portion of any vested or unvested Options held by Optionee without payment and/or be required to repay or otherwise reimburse the Company for the gain or value realized in respect of all or a portion of any exercised Options.

1. If Optionee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Optionee shall immediately forfeit as of the date that the violation first occurs all unexercised Options described above in Section I(A) (whether vested or unvested) without payment. This provision does not alter the circumstances for forfeiture of unexercised Options as described in Section I(D) of this Agreement.

2. If Optionee has exercised any of the Options prior to the Forfeiture Event, then for any Option that has been exercised during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Optionee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to the amount described below.

To the extent that (i) any Shares related to exercised Options have been sold or transferred, the amount shall be the aggregate gross proceeds realized by Optionee from such sale or transfer of the net Shares acquired after payment of the exercise price and any applicable taxes (the "**Net Shares**") (or, in the case of any disposition or transfer of the Net Shares for less than the Fair Market Value of such Net Shares, Optionee will repay or reimburse to the Company an amount equal

to the Fair Market Value of such Net Shares) or (ii) if the Net Shares have not been sold at the time Company demand is made, the amount shall be the aggregate Fair Market Value of the Net Shares on the date the Options were exercised.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Optionee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Optionee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Options. By receiving the Options, Optionee agrees upon Optionee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes Optionee following the Last Day any amounts Optionee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Optionee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Optionee realizes any amounts in excess of what he or she should have received under the terms of any Options for any reason due to mistake in calculations or other administrative error, then Optionee shall be required to repay or reimburse any such excess amounts to the Company within thirty (30) days following the Company's written demand for repayment.

G. **Governing Law.** Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. **Injunctive Relief; Invalidity of Any Provision.** Optionee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Optionee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Optionee's unfair competition or wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Optionee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Optionee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether

as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

I. Notice of Agreement. Optionee agrees that, during the Restricted Period, Optionee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Optionee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Optionee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. Tolling. In the event Optionee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Optionee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Optionee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Optionee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Optionee and all rights granted to Optionee and to the Company shall be binding upon Optionee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. Jurisdiction; Service of Process. Any action or proceeding seeking to enforce any provision of, or based on any right arising out of, this Agreement may be brought against any of the parties in the courts of the Commonwealth of Kentucky, County of Jefferson, or, if it has or can acquire jurisdiction, in the United States District Court for the Western District of Kentucky, and each of the parties consents to the jurisdiction of such courts (and of the appropriate appellate courts) in any such action or proceeding and waives any objection to venue laid therein. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere in the world.

E. No Employment Agreement. Nothing herein confers on Optionee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Optionee's employment or other service at any time.

F. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed

amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect. Any provision in this Agreement determined by competent authority to be in conflict with 422 of the Internal Revenue Code of 1986, as amended, or its successor, in regard to qualifying this Option as an incentive stock option shall be ineffective ab initio to the extent of such conflict.

G. Assignment. The Option granted under this Agreement to Optionee may not be assigned, transferred, pledged, alienated or hypothecated in any manner during Optionee's lifetime, but shall be solely and exclusively the right of Optionee to exercise during his/her lifetime. Should Optionee attempt to assign, transfer, pledge, alienate or hypothecate the Option or any rights hereunder in any manner whatsoever, such action shall constitute a breach of the covenants hereunder and the Company may terminate the Option as to any then unexercised shares.

H. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Optionee and any person or persons claiming through Optionee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event the Option is assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Optionee is terminated within two (2) years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Optionee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Optionee worked or for which Optionee had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Optionee's Last Day (as defined below).

(iii) "**Competitor**" means Optionee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Last Day**" means Optionee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Optionee's separation.

(v) "**Protected Relationship**" means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, long-term care facilities, state Medicaid agencies, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, customers, and/or sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Optionee, directly or indirectly (*e.g.*, through employees whom Optionee supervised) had material business contact and/or about whom Optionee obtained confidential information and trade secrets.

(vi) "**Restricted Geographic Area**" means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Optionee provided material services on behalf of the Company (or in which Optionee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) "**Restricted Period**" means the period of Optionee's employment with the Company, its subsidiaries', and/or its affiliates' and a period of twelve (12) months after the Last Day. Optionee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) "**Solicit**" means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Optionee or indirectly through another individual.

I. Execution. If Optionee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Optionee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Optionee"

_____
<first_name> <middle_name> <last_name>

Humana Inc. ("Humana") has granted you the number of shares of restricted stock of Humana set forth below in this Restricted Stock Grant Agreement ("Restricted Stock Grant" or "Grant") under the Amended and Restated Stock Incentive Plan. **The award is subject to the provisions of the Plan and the Terms and Conditions below**.

YOU SHOULD CAREFULLY READ ALL THE TERMS AND CONDITIONS OF THIS RESTRICTED STOCK GRANT AND BE SURE YOU UNDERSTAND WHAT THEY SAY AND WHAT YOUR RESPONSIBILITIES AND OBLIGATIONS ARE BEFORE YOU CLICK ON THE "ACCEPT" BUTTON TO ACKNOWLEDGE AND AGREE TO THIS GRANT.

If you are not willing to agree to all of the Grant terms and conditions, do not click the ACCEPT button for the Restricted Stock Grant Acknowledgement and Agreement. If you do not accept the Grant, you will not receive the benefits of the Grant.

If you do click the ACCEPT button, you are accepting and agreeing to all of the terms and conditions of this Restricted Stock Grant, which include, among other things, certain restrictive covenants that may include non-competition and/or non-solicitation provisions.

Please be aware that the Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality places restrictions on your transactions in Humana securities and requires certain Humana employees to obtain advance permission from the Equity Compliance Team before executing transactions in Humana securities.

If you have any questions about your award, please contact EquityCompliance@humana.com.

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT WITH PERFORMANCE VESTING
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>**,** an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Performance-Based Restricted Stock Units (the "Restricted Stock Units") (which represents the target amount of shares available as set out on Appendix A). Each Restricted Stock Unit represents the right of Grantee to receive (i) one (1) Share on the date of distribution provided for in Section I(E). In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("DERs"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I(E). hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I(B) through I(E), inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I(D) hereof, the related DER shall also be forfeited.

B. **Restrictions and Non-Transferability.** The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I(D).

C. **Vesting of Shares.** Subject to the terms set forth below, if as of the third anniversary of the Date of Grant (the "Vesting Date"), Grantee and the Company have achieved the performance goals to be set forth in Appendix A, the Restricted Stock Units and related DERs shall vest to the extent such performance goals have been achieved. Effective on the Vesting Date, any portion of the Restricted Stock Units and the related DERs for which the performance goals set forth in Appendix A have not been satisfied shall be immediately forfeited. However, notwithstanding the foregoing, upon certain terminations of employment (as set forth below), all or a portion of the unvested Restricted Stock Units and DERs will vest in accordance with Sections 12 and 13 of the Plan.

D. **Forfeiture.** Except as set forth in Sections 12 and 13 of the Plan, upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

E. **Distributions**. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I(C) hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination (defined below), then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I(C) hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. **Taxes**. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. **Agreement Not to Compete.**

1. Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Grantee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee, during the Restricted Period, will not work on or provide Competitive Products or Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Grantee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Grantee is or will be in violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Grantee commences employment for the Competitor. Such "Written Assurances"

shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Grantee worked, had business contact, or about which Grantee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Restricted Stock Units that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Restricted Stock Units, assuming target performance has been achieved (or by the number of Shares underlying the Restricted Stock Unit that become vested as a result of the acceleration of vesting, if any), by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II(A), the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not

related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II(B) and II(C) shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Grantee shall forfeit all or a portion of any vested or unvested Restricted Stock Units without payment and/or be required to repay or otherwise reimburse the Company any gain or value realized in respect of all or a portion of the Restricted Stock Units.

1. If Grantee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Grantee shall immediately forfeit as of the date that the violation first occurs all unvested Restricted Stock Units. This provision does not alter the circumstances for forfeiture of unvested Restricted Stock Units as described in Section I(D) of this Agreement.

2. For any Restricted Stock Units that vested during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Grantee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to (i) equal to the aggregate Fair Market Value of the shares of Stock underlying such Restricted Stock Units on the date the Restricted Stock Units became vested and (ii) any dividend or DER amounts paid in respect of Shares.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Grantee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Grantee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Restricted Stock Units. By receiving the Restricted Stock Units, Grantee agrees upon Grantee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes Grantee following the Last Day any amounts Grantee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Grantee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Grantee realizes any amounts in excess of what Grantee should have received under the terms of any Restricted Stock Units for any reason due to mistake in calculations or other administrative error, then Grantee shall be required to repay or reimburse any such excess amounts

to the Company within thirty (30) days following the Company's written demand for repayment.

G. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. Injunctive Relief; Invalidity of Any Provision. Grantee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Grantee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Grantee's unfair competition or wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

I. Notice of Agreement. Grantee agrees that, during the Restricted Period, Grantee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Grantee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Grantee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. Tolling. In the event Grantee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Grantee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Grantee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. No Employment Agreement. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any

disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Grantee is terminated within two years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Grantee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked, had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Grantee's Last Day (defined below).

(iii) "**Competitor**" means Grantee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Last Day**" means Grantee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Grantee's separation.

(v) "**Protected Relationship**" means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, state Medicaid agencies, long-term care facilities, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, customers, and/or other sources of supply or customers with whom within twenty-four months prior to the Last Day, Grantee, directly or indirectly (*e.g.*, through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(vi) "**Restricted Geographic Area**" means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) "**Restricted Period**" means the period of Grantee's employment with the Company, its subsidiaries, and/or its affiliates and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

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G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

GRANTEE CERTIFIES THAT GRANTEE HAS READ AND UNDERSTANDS THIS AGREEMENT AND THE RESTRICTIONS CONTAINED THEREIN, AND HAS HAD AN OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL PRIOR TO SIGNING. GRANTEE ACKNOWLEDGES THAT THIS AGREEMENT MAY BE ACCEPTED ELECTRONICALLY BY GRANTEE, AND THAT AN ELECTRONIC COPY, HARD COPY, OR ACKNOWLEDGEMENT IS AS ENFORCEABLE AS AN ORIGINAL. GRANTEE ACKNOWLEDGES THAT GRANTEE HAD ABILITY TO PRINT A COPY OF THIS AGREEMENT AND TIME TO REVIEW IT PRIOR TO SIGNING.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

HUMANA INC.

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

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YOU SHOULD CAREFULLY READ ALL THE TERMS AND CONDITIONS OF THIS RESTRICTED STOCK GRANT AND BE SURE YOU UNDERSTAND WHAT THEY SAY AND WHAT YOUR RESPONSIBILITIES AND OBLIGATIONS ARE BEFORE YOU CLICK ON THE "ACCEPT" BUTTON TO ACKNOWLEDGE AND AGREE TO THIS GRANT.

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HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT ("Agreement") made as of <award_date> (the "Date of Grant") by and between HUMANA INC., a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the "Company"), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as "Grantee").

WITNESSETH:

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the "Plan") was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Restricted Stock Units. Each Restricted Stock Unit represents the right of Grantee to receive (i) one (1) Share on the date of distribution provided for in Section I.E. In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("DERs"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I.E. hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I.B through I.E., inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I.D. hereof, the related DER shall also be forfeited.

B. Restrictions and Non-Transferability. The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I.D.

C. Vesting of Restricted Stock Units. The Restricted Stock Units shall vest in three equal installments, with the first installment vesting on the Anniversary Date of the Grant, and the next two

installments vesting on each year of the next two anniversaries of the Date of Grant (each such date, a "Vesting Date") subject to Grantee's continued employment with the Company through each such Vesting Date, except as set forth in Sections 12 and 13 of the Plan, or as set forth below:

1. Section 13(c)(ii) of the Plan and any references to "Retirement" in any other section of the Plan will not apply to the Restricted Stock Units.

2. Notwithstanding Section 13(e)(ii)(B) of the Plan, in the event that Grantee's employment with the Company terminates due to a Divestiture of the business to which Grantee provides services, if the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, all outstanding Restricted Stock Units (and related DERs) shall continue to vest on the regular Vesting Date(s) in the same manner as if Grantee continued to be employed by the Company through the applicable Vesting Date(s).

3. Notwithstanding Section 13(g)(ii) of the Plan, in the event that Grantee's employment with the Company terminates due to a Workforce Reduction or a Position Elimination, all outstanding Restricted Stock Units (and related DERs) shall continue to vest on the regular Vesting Date(s) in the same manner as if Grantee continued to be employed by the Company through the applicable Vesting Date(s).

D. Forfeiture. Except as set forth in Sections 12 and 13 of the Plan (as modified by Section C above), upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

E. Distributions. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I.C hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination (defined below), then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I.C. hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the

contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. Taxes. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("Withholding Taxes") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Grantee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee, during the Restricted Period, will not work on or provide Competitive Products or Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Grantee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Grantee is or will be in

violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Grantee commences employment for the Competitor. Such "Written Assurances" shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Grantee worked, had business contact, or about which Grantee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Restricted Stock Units that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Restricted Stock Units, assuming target performance has been achieved (or by the number of Shares underlying the Restricted Stock Unit that become vested as a result of the acceleration of vesting, if any), by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other

amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II(B) and II.C shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Grantee shall forfeit all or a portion of any vested or unvested Restricted Stock Units without payment and/or be required to repay or otherwise reimburse the Company for the gain or value realized in respect of all or a portion of the Restricted Stock Units.

1. If Grantee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Grantee shall immediately forfeit as of the date that the violation first occurs all unvested Restricted Stock Units without payment.. This provision does not alter the circumstances for forfeiture of unvested Restricted Stock Units as described in Section I(D) of this Agreement.

2. For any Restricted Stock Units that vested during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Grantee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to (i) equal to the aggregate Fair Market Value of the shares of Stock underlying such Restricted Stock Units on the date the Restricted Stock Units became vested and (ii) any dividend or DER amounts paid in respect of Shares.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Grantee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Grantee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Restricted Stock Units. By receiving the Restricted Stock Units, Grantee agrees upon Grantee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes the Grantee following the Last Day any amounts Grantee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Grantee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Grantee realizes any amounts in excess of what Grantee should have received under the terms of any Restricted Stock Units for any reason due to mistake in calculations or other administrative error, then Grantee shall be required to repay or reimburse any such excess amounts to the Company within thirty (30) days following the Company's written demand for repayment.

G. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to Kentucky's conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. Injunctive Relief; Invalidity of Any Provision. Grantee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Grantee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Grantee's unfair competition or wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

I. Notice of Agreement. Grantee agrees that, during the Restricted Period, Grantee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Grantee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Grantee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. Tolling. In the event Grantee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Grantee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Grantee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. No Employment Agreement. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the

Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "Change in Control Termination" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Grantee is terminated within two years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Grantee with Good Reason.

(ii) "Competitive Product or Service" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked, had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Grantee's Last Day (defined below).

(iii) "Competitor" means Grantee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "Last Day" means Grantee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Grantee's separation.

(v) "Protected Relationship" means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, long-term care facilities, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, state Medicaid agencies, customers, and/or other sources of supply or customers with whom within twenty-four months prior to the Last Day, Grantee, directly or indirectly (*e.g.*, through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(vi) "Restricted Geographic Area" means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) "Restricted Period" means the period of Grantee's employment with the Company, its subsidiaries, and/or its affiliates and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) "Solicit" means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Grantee or indirectly through another individual.

G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

GRANTEE CERTIFIES THAT GRANTEE HAS READ AND UNDERSTANDS THIS AGREEMENT AND THE RESTRICTIONS CONTAINED THEREIN, AND HAS HAD AN OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL PRIOR TO SIGNING. GRANTEE ACKNOWLEDGES THAT THIS AGREEMENT MAY BE ACCEPTED ELECTRONICALLY BY GRANTEE, AND THAT AN ELECTRONIC COPY, HARD COPY, OR ACKNOWLEDGEMENT IS AS ENFORCEABLE AS AN ORIGINAL. GRANTEE ACKNOWLEDGES THAT GRANTEE HAD ABILITY TO PRINT A COPY OF THIS AGREEMENT AND TIME TO REVIEW IT PRIOR TO SIGNING.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

HUMANA INC.

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

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Humana Inc. ("Humana") has granted you the number of shares of restricted stock of Humana set forth below in this Restricted Stock Grant Agreement ("Restricted Stock Grant" or "Grant") under the Amended and Restated Stock Incentive Plan. **The award is subject to the provisions of the Plan and the Terms and Conditions below**.

YOU SHOULD CAREFULLY READ ALL THE TERMS AND CONDITIONS OF THIS RESTRICTED STOCK GRANT AND BE SURE YOU UNDERSTAND WHAT THEY SAY AND WHAT YOUR RESPONSIBILITIES AND OBLIGATIONS ARE BEFORE YOU CLICK ON THE "ACCEPT" BUTTON TO ACKNOWLEDGE AND AGREE TO THIS GRANT.

If you are not willing to agree to all of the Grant terms and conditions, do not click the ACCEPT button for the Restricted Stock Grant Acknowledgement and Agreement. If you do not accept the Grant, you will not receive the benefits of the Grant.

If you do click the ACCEPT button, you are accepting and agreeing to all of the terms and conditions of this Restricted Stock Grant, which include, among other things, certain restrictive covenants that may include non-competition and/or non-solicitation provisions.

Please be aware that the Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality places restrictions on your transactions in Humana securities and requires certain Humana employees to obtain advance permission from the Equity Compliance Team before executing transactions in Humana securities.

If you have any questions about your award, please contact EquityCompliance@humana.com.

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE AMENDED AND RESTATED STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>**,** an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Amended and Restated Humana Inc. Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Restricted Stock Units. Each Restricted Stock Unit represents the right of Grantee to receive one (1) Share on the date of distribution provided for in Section I(E). In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("**DERs**"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I(E) hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I(B) through I(E), inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I(D) hereof, the related DER shall also be forfeited.

B. Restrictions and Non-Transferability. The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I(D).

C. Vesting of Shares. The Restricted Stock Units shall vest in three equal installments, with the first installment vesting on December 15 of the year in which the Date of Grant occurs, and the next two installments vesting on December 15 of each of the next two years (each such date, a "**Vesting Date**" and the period between each Vesting Date or between the Date of Grant and a Vesting Date, as applicable, a "**Vesting Period**") subject to Grantee's continued employment with the Company through each such Vesting Date; However, notwithstanding the foregoing, upon certain terminations of employment (as set forth below), all or a portion of the unvested Restricted Stock Units and DERs will vest in accordance with Sections 12 and 13 of the Plan.

D. Forfeiture. Except as set forth in Sections 12 and 13 of the Plan, upon the Last Day, but prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

E. Distributions. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I(C) hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination (defined below), then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I(C) hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. Taxes. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete.

1. Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform or engage in Competitive Product or Services (defined below) with a Competitor (defined below). Grantee may not accept employment with a Competitor (defined below) unless the Competitor's business is diversified and the Company receives Written Assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee, during the Restricted Period, will not work on or provide Competitive Products or

Services or otherwise use or disclose the Company's confidential information or trade secrets.

2. For Section II(A), such "Written Assurances" must contain a written statement detailing the identity of the Competitor and the nature of the services that Grantee will provide to the Competitor with sufficient detail to allow the Company to independently assess whether Grantee is or will be in violation of the Agreement. The Company must also receive such "Written Assurances" at least ten business days before Grantee commences employment for the Competitor. Such "Written Assurances" shall be delivered to the Company's Chief Human Resource Officer or his/her authorized delegate.

3. Nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period (defined below) and in connection with a Competitive Product or Service (defined below), Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit (defined below) any Protected Relationships (defined below); or (2) Solicit any Protected Relationships to terminate a relationship with the Company, its subsidiaries, and/or its affiliates, reduce the volume of their business dealings with the Company, its subsidiaries, and/or its affiliates, or to otherwise cease to accept services or products from the Company, its subsidiaries, and/or its affiliates.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly, or by assisting others, (1) Solicit any employees or former employees of the Company, its subsidiaries, and/or its affiliates with whom Grantee worked, had business contact, or about which Grantee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of Soliciting them to terminate their employment or find employment or work with another person or entity; (3) provide, share, or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide, share, or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company, its subsidiaries, and/or its affiliates at the time of the attempted recruiting or hiring, but were employed by, or working for the Company, its subsidiaries, and/or its affiliates in the three months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II(A), II(B) and II(C) shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II(A) shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed

to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Restricted Stock Units that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Restricted Stock Units, assuming target performance has been achieved (or by the number of Shares underlying the Restricted Stock Unit that become vested as a result of the acceleration of vesting, if any), by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II(B) and II(C) above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II(E).

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II(D), in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II(A) shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following the Last Day (with the Company or its successor), to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II(E) shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II(A), with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II(B) and II.C shall remain in full force and effect.

F. Violation of Restrictive Covenants. This subsection sets forth the circumstances under which Grantee shall forfeit all or a portion of any vested or unvested Restricted Stock Units without payment and/or be required to repay or otherwise reimburse the Company for the gain or value realized in respect of all or a portion of the Restricted Stock Units.

1. If Grantee violates any provisions of Section II of this Agreement (a "Forfeiture Event"), Grantee shall immediately forfeit as of the date that the violation first occurs all unvested Restricted Stock Units without payment.. This provision does not alter the circumstances for forfeiture of unvested Restricted Stock Units as described in Section I(D) of this Agreement.

2. For any Restricted Stock Units that vested during the 12 month period prior to the Forfeiture Event or at any time after the Forfeiture event, Grantee shall be required to repay or otherwise reimburse the Company, immediately upon demand, an amount in Cash or Humana Inc. common stock equal to (i) equal to the aggregate Fair Market Value of the shares

of Stock underlying such Restricted Stock Units on the date the Restricted Stock Units became vested and (ii) any dividend or DER amounts paid in respect of Shares.

3. The relief provided in this Section II(F) of the Agreement does not constitute the Company's exclusive remedy for the Grantee's violation of any of the provisions of Section II of the Agreement. As any forfeiture and repayment provisions are not adequate remedies at law, including because they do not repair the irreparable harm the Company will suffer from Grantee's breaches of this Agreement, the Company may seek any additional legal or equitable remedy, including injunctive relief, for such violations. The provisions in this section are essential economic conditions to the Company's grant of Restricted Stock Units. By receiving the Restricted Stock Units, Grantee agrees upon Grantee's violation of Section II of this Agreement that the Company may, subject to applicable state law, deduct from any amounts the Company owes the Grantee following the Last Day any amounts Grantee owes the Company under Section II(F).

4. The provisions under this Section II(F) of the Agreement and any amounts repayable by Grantee hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002 and other applicable law.

5. In addition, if Grantee realizes any amounts in excess of what Grantee should have received under the terms of any Restricted Stock Units for any reason due to mistake in calculations or other administrative error, then Grantee shall be required to repay or reimburse any such excess amounts to the Company within thirty (30) days following the Company's written demand for repayment.

G. **Governing Law.** Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

H. **Injunctive Relief; Invalidity of Any Provision.** Grantee acknowledges that (1) his or her services to the Company, its subsidiaries, and/or its affiliates are of a special, unique and extraordinary character, (2) his or her position with the Company, its subsidiaries, and/or its affiliates will place him or her in a position of confidence and trust with respect to the operations of the Company, its subsidiaries, and/or its affiliates, (3) he or she will benefit from continued employment with the Company, its subsidiaries, and/or its affiliates, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, its subsidiaries, and/or its affiliates, (5) the Company, its subsidiaries, and/or its affiliates would sustain immediate and irreparable loss and damage from Grantee's wrongful use or disclosure of the Company, its subsidiaries, and/or its affiliates' confidential information or trade secrets and from Grantee's unfair competition or wrongful Solicitation of Protected Relationships, including with respect to the impairment of the Company's, its subsidiaries', and/or its affiliates' goodwill in its Protected Relationships, and (6) for the same reason, the Company's remedy at law (including under any forfeiture under Section II(F) above) for any such breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek temporary, preliminary, and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any part or provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended (and the court is authorized to amend), whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents

necessary to evidence such amendment.

I. Notice of Agreement. Grantee agrees that, during the Restricted Period, Grantee will tell any prospective new employer, partner, in a business venture, investors and/or any entity seeking to engage Grantee's services, prior to accepting employment, engagement as a consultant or contractor, or engaging in a business venture that this Agreement exists, and further, Grantee agrees to provide a true and correct copy of this Agreement to any such individual or entity prior to accepting any such employment or entering into any such employment or business venture.

J. Tolling. In the event Grantee violates one of the time-limited restrictions in Section II of this Agreement, the Company reserves the right to request as a form or equitable relief, and Grantee will not object, that a court of competent jurisdiction extend the time period for such violated restriction by one day for each day Grantee violated the restriction, up to the maximum extension equal to the length of the original period of the time-limited restrictions in Section II of this Agreement.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. No Employment Agreement. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in Control in accordance with Section 11.1 of the Plan, if the employment of Grantee is terminated within two years following the Change in Control (a) by the Company or its acquirer or successor for any reason other than Cause or (b) by Grantee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked, had direct or indirect responsibilities, or had confidential information about at the Company during the twenty-four (24) months prior to the Grantee's Last Day (defined below).

(iii) "**Competitor**" means Grantee or any other person or organization, other than the Company or any of its subsidiaries, engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Last Day**" means Grantee's last day of employment with the Company, its subsidiaries, and/or its affiliates (or immediate successor) regardless of the reason for Grantee's separation.

(v) "**Protected Relationship**" means, but is not necessarily limited to, vendors, healthcare providers, hospitals, hospital systems, lobbyists, state Medicaid agencies, long-term care facilities, pharmaceutical manufacturers, policyholders, agents, brokers, dealers, distributers, customers, and/or other sources of supply or customers with whom within twenty-four months prior to the Last Day, Grantee, directly or indirectly (*e.g.*, through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(vi) "**Restricted Geographic Area**" means the territory (*i.e.*: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(vii) "**Restricted Period**" means the period of Grantee's employment with the Company, its subsidiaries, and/or its affiliates and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's, its subsidiaries', and/or its affiliates' legitimate business interest and need for protection with each position.

(viii) "**Solicit**" means to hire, entice, encourage, persuade, recruit, or solicit, or attempt to hire, entice, encourage, persuade, recruit, or solicit, either directly by Grantee or indirectly through another individual.

G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary,

Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

GRANTEE CERTIFIES THAT GRANTEE HAS READ AND UNDERSTANDS THIS AGREEMENT AND THE RESTRICTIONS CONTAINED THEREIN, AND HAS HAD AN OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL PRIOR TO SIGNING. GRANTEE ACKNOWLEDGES THAT THIS AGREEMENT MAY BE ACCEPTED ELECTRONICALLY BY GRANTEE, AND THAT AN ELECTRONIC COPY, HARD COPY, OR ACKNOWLEDGEMENT IS AS ENFORCEABLE AS AN ORIGINAL. GRANTEE ACKNOWLEDGES THAT GRANTEE HAD ABILITY TO PRINT A COPY OF THIS AGREEMENT AND TIME TO REVIEW IT PRIOR TO SIGNING.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer

HUMANA INC.

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ARKANSAS
1. Humana Regional Health Plan, Inc.

CALIFORNIA
1. Humana EAP and Work-Life Services of California, Inc.
2. Humana Health Plan of California, Inc.

DELAWARE
1. Atlantis Physician Group, LLC
2. CDO 1, LLC
3. CDO 2, LLC
4. CompBenefits Corporation
5. CompBenefits Direct, Inc.
6. Conviva Care Solutions, LLC
7. Conviva Care Solutions II, LLC
8. Conviva Group Holdings, LLC
9. Conviva Health Management, LLC
10.. Conviva Health MSO of Texas, Inc.
11. Conviva Medical Center Management, LLC
12. Eagle NY Rx, LLC
13. Eagle Rx Holdco, Inc.
14. Eagle Rx, Inc.
15. Edge Health MSO, Inc.
16. Emphesys, Inc.
17. Enclara Pharmacia, Inc.
18. FPG Acquisition Corp.
19. FPG Acquisition Holdings Corp.
20. FPG Holding Company, LLC
21. Go365, LLC
22. Health Value Management, Inc.
23. HUM Provider Holdings, LLC
24. Humana at Home, Inc.
25. Humana Digital Health and Analytics Platform Services, Inc.
26. Humana Direct Contracting Entity, Inc.
27. Humana Government Business, Inc.
28. Humana Inc.
29. Humana Innovation Enterprises, Inc.
30. Humana Pharmacy, Inc.
31. Humana WellWorks LLC
32. HumanaDental, Inc.
33. North Region Providers, LLC
34. PBM Holding Company
35. PBM Plus Mail Service Pharmacy, LLC
36. Primary Care Holdings II, LLC
37. Primary Care Management, Inc.
38. Transcend Population Health Management II, LLC

FLORIDA

1. 154th Street Medical Plaza, Inc.
2. 54th Street Medical Plaza, Inc.
3. CAC Medical Center Holdings, Inc.
4. CAC-Florida Medical Centers, LLC
5. Care Partners Home Care, LLC
6. CarePlus Health Plans, Inc.
7. CompBenefits Company
8. Complex Clinical Management, Inc.
9. Continucare Corporation
10. Conviva Specialty, LLC
11. Family Physicians of Winter Park, Inc.
12. FPG Senior Services, LLC
13. HUM-e-FL, Inc.
14. Humana At Home 1, Inc.
15. Humana Dental Company
16. Humana Health Insurance Company of Florida, Inc.
17. Humana Medical Plan, Inc.
18. METCARE of Florida, Inc.
19. Metropolitan Health Networks, Inc.
20. Naples Health Care Specialists, LLC
21. Nursing Solutions, LLC
22. RMA Island Doctors Orlando MSO, LLC
23. RMA Medical Center of Orlando, LLC
24. RMA Medical Center of South Orlando, LLC
25. SeniorBridge Family Companies (FL), Inc.
26. SeniorBridge-Florida, LLC

GEORGIA

1. Humana Employers Health Plan of Georgia, Inc.

ILLINOIS

1. CompBenefits Dental, Inc.
2. Dental Care Plus Management, Corp.
3. Humana Benefit Plan of Illinois, Inc.
4. Humana Healthcare Research, Inc.

INDIANA

1. SeniorBridge Family Companies (IN), Inc.

KENTUCKY

1. 516-526 West Main Street Condominium Council of Co-Owners, Inc.
2. CHA HMO, Inc.
3. Humana Active Outlook, Inc.
4. Humana Health Plan, Inc.

5 Humana Insurance Company of Kentucky

6. Humana MarketPOINT, Inc.
7. Humana Pharmacy Solutions, Inc.

8. Humana Real Estate Company
9. Humco, Inc.
10. The Dental Concern, Inc.

LOUISIANA
1. Humana Health Benefit Plan of Louisiana, Inc.

MICHIGAN
1. Humana Medical Plan of Michigan, Inc.

NEW YORK
1. Alexander Infusion, LLC
2. Harris, Rothenberg International Inc.
3. Humana Health Company of New York, Inc.
4. Humana Insurance Company of New York
5. SeniorBridge Family Companies (NY), Inc.

OHIO
1. Humana Health Plan of Ohio, Inc.
2. Hummingbird Coaching Systems LLC

PENNSYLVANIA
1. Humana Medical Plan of Pennsylvania, Inc.

PUERTO RICO
1. Humana Health Plans of Puerto Rico, Inc.
2. Humana Insurance of Puerto Rico, Inc.
3. Humana Management Services of Puerto Rico, Inc.
4. Humana MarketPOINT of Puerto Rico, Inc.

South Carolina
1. Humana Benefit Plan of South Carolina, Inc.

TENNESSEE
1. Cariten Health Plan Inc.
2. PHP Companies, Inc.
3. Preferred Health Partnership, Inc.

TEXAS
1. CompBenefits Insurance Company
2. DentiCare, Inc.
3. Emphesys Insurance Company
4. Humana At Home (Dallas), Inc.
5. Humana At Home (Houston), Inc.
6. Humana At Home (San Antonio), Inc.
7. Humana At Home (TLC), Inc.
8. Humana Benefit Plan of Texas, Inc.
9. Humana Health Plan of Texas, Inc.
10. Medical Care Consortium Incorporated of Texas
11. ROHC, L.L.C.
12. Texas Dental Plans, Inc.

UTAH
1. Humana Medical Plan of Utah, Inc.

VERMONT
1. Managed Care Indemnity, Inc.

WASHINGTON
1. Arcadian Health Plan, Inc.

WISCONSIN
1. CareNetwork, Inc.
2. GuidantRx, Inc.
3. Humana Insurance Company
4. Humana Wisconsin Health Organization Insurance Corporation
5. HumanaDental Insurance Company
6. Independent Care Health Plan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (No. 33-49305, No. 333-04435, No. 333-57095, No. 333-86801, No. 333-41408, No. 333-86280, No. 333-105622, No. 333-134887, No. 333-162747, No. 333-171616, and No. 333-175350) and S-3 (No. 333-223554) of Humana Inc. of our report dated February 18, 2021 relating to the financial statements and financial statement schedules and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

February 18, 2021

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Bruce D. Broussard, principal executive officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 18, 2021

Signature: /s/ BRUCE D. BROUSSARD

Bruce D. Broussard
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Brian A. Kane, principal financial officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 18, 2021

Signature: /s/ BRIAN A. KANE
Brian A. Kane
Principal Financial Officer

Exhibit 32

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Humana Inc. (the "Company") on Form 10-K for the period ended December 31, 2020 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ BRUCE D. BROUSSARD

Bruce D. Broussard
President and Chief Executive Officer,
Director (Principal Executive Officer)

February 18, 2021

/s/ BRIAN A. KANE

Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

February 18, 2021

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

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

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

For the fiscal year ended December 31, 2019
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 or other jurisdiction of incorporation of organization)	(I.R.S. Employer Identification No.)

500 West Main Street, Louisville, Kentucky 40202
(Address of principal executive offices, and 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	Trading Symbol	Name of exchange on which registered
Common stock, $0.16 2/3 par value	**HUM**	**New York Stock Exchange**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	Accelerated filer
Non-accelerated filer	Smaller reporting company
	Emerging growth company

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

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

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30,2019 was $35,478,894,483 calculated using the average price on June 30, 2019 of $263.21.

The number of shares outstanding of the Registrant's Common Stock as ofJanuary 31, 2020 was 132,106,497.

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 23, 2020.

HUMANA INC.
INDEX TO ANNUAL REPORT ON FORM 10-K
For the Year Ended December 31, 2019

		Page
	Part I	
Item 1.	Business	3
Item 1A.	Risk Factors	19
Item 1B.	Unresolved Staff Comments	33
Item 2.	Properties	33
Item 3.	Legal Proceedings	34
Item 4.	Mine Safety Disclosures	34
	Part II	
Item 5.	Market for the Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	35
Item 6.	Selected Financial Data	38
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	39
Item 7A.	Quantitative and Qualitative Disclosures about Market Risk	65
Item 8.	Financial Statements and Supplementary Data	67
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	124
Item 9A.	Controls and Procedures	124
Item 9B.	Other Information	125
	Part III	
Item 10.	Directors, Executive Officers and Corporate Governance	126
Item 11.	Executive Compensation	127
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	127
Item 13.	Certain Relationships and Related Transactions, and Director Independence	128
Item 14.	Principal Accounting Fees and Services	128
	Part IV	
Item 15.	Exhibits, Financial Statement Schedules	129
Item 16.	Form 10-K Summary	141
	Signatures and Certifications	142

Forward-Looking Statements

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

PART I

ITEM 1. BUSINESS

General

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

As of December 31, 2019, we had approximately 17 million members in our medical benefit plans, as well as approximately 5 million members in our specialty products. During 2019, 82% of our total premiums and services revenue were derived from contracts with the federal government, including 15% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 701,400 members as of December 31, 2019.

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 2019 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2019 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Business Segments

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as

well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable 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, the chief operating decision maker, to assess performance and allocate resources. See Note 18 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

Our Products

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

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2019:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 43,128	67.0%
Group Medicare Advantage	6,475	10.1%
Medicare stand-alone PDP	3,165	4.9%
Total Retail Medicare	52,768	82.0%
State-based Medicaid	2,898	4.5%
Medicare Supplement	588	0.9%
Total premiums	56,254	87.4%
Services	17	—%
Total premiums and services revenue	$ 56,271	87.4%

Medicare

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

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

Individual Medicare Advantage Products

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

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

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

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score was calculated from claims data submitted through EDS. CMS will increase that percentage to 50% in 2020 and has proposed to increase that percentage to 75% in 2021. For more information refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data and Item 1A. - Risk Factors.

At December 31, 2019, we provided health insurance coverage under CMS contracts to approximately 3,587,200 individual Medicare Advantage members, including approximately 701,400 members in Florida. These Florida contracts accounted for premiums revenue of approximately $9.5 billion, which represented approximately 22.0% of our individual Medicare Advantage premiums revenue, or 15.0% of our consolidated premiums and services revenue for the year ended December 31, 2019.

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 2020, and all of our product offerings filed with CMS for 2020 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, titled "Medicare Part D." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2020, and all of our product offerings filed with CMS for 2020 have been approved.

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

Group Medicare Advantage and Medicare stand-alone PDP

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

State-based Medicaid Contracts

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

We have contracts to serve Medicaid eligible members in Florida and Kentucky under traditional programs, as well as contracts in Florida under the LTSS program. Prior to January 1, 2020, our Kentucky Medicaid contract was subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource. Effective January 1, 2020, we terminated the reinsurance agreement with CareSource and assumed full administration of our Kentucky Medicaid contract.

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. States require special coordinating contracts for plans to offer Medicare Advantage dual eligible special needs plans, or D-SNPs. These largely operate separate from traditional Medicaid and LTSS programs. Some states are moving to support the dual eligible population by linking D-SNP participation to enrollment in a plan that also participates in a state-based Medicaid program to coordinate and integrate both Medicare and Medicaid benefits. Beginning in 2021, based on new federal requirements, states are expected to strengthen Medicaid-Medicare integration requirements for D-SNPs.

We currently serve dual eligible members under the CMS stand-alone dual eligible demonstration program in Illinois, and continue to serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans.

Our Group and Specialty Segment Products

The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision and life insurance benefits, as well as administrative services only, or ASO products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group and Specialty segment by product for the year ended December 31, 2019:

	Group and Specialty Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 5,123	8.0%
Specialty	1,571	2.4%
Total premiums	6,694	10.4%
Services	790	1.2%
Total premiums and services revenue	$ 7,484	11.6%
Intersegment services revenue	$ 18	n/a

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts.

Our administrative services only, or ASO, products are offered to small group and large group 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 the costs of health benefits, with large group customers retaining a greater share and small group customers a smaller share of the cost of health benefits. All small group ASO customers and many large group ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

Employers can customize their offerings with optional benefits such as dental, vision, and life products. We also offer optional benefits such as dental and vision to individuals.

Military Services

Under our TRICARE contracts with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. Under our contracts, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. On January 1, 2018, we began to deliver services under the T2017 East Region contract. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries. The T2017 East Region

contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, clinical care services, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 18 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, 2019:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 22,189	n/a
Provider services	2,344	n/a
Clinical care services	616	n/a
Total intersegment revenue	$ 25,149	
External services revenue:		
Pharmacy solutions	$ 186	0.3%
Provider services	306	0.5%
Clinical care services	140	0.2%
Total external services revenue	$ 632	1.0%

n/a – not applicable

Pharmacy solutions

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

Provider services

We operate full-service, multi-specialty medical centers in a number of states, including Florida, Kansas, Missouri, North Carolina, South Carolina, and Texas, staffed by primary care providers and medical specialists with a primary focus on the senior population. We operate these clinics primarily under the Conviva, Partners in Primary Care or Family Physicians Group brands. Our care delivery subsidiaries operate our medical center business through both employed physicians and care providers, and through third party management service organizations with whom we contract to arrange for and manage certain clinical services.

We also operate a Medical Services Organization, or MSO, through Conviva that coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. This MSO 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. Conviva's MSO 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.

In February 2020, Partners in Primary Care entered into a strategic partnership with Welsh, Carson, Anderson & Stowe to open a minimum of 50 additional payor-agnostic, senior-focused primary care centers over the next three

years and in 2018 we acquired Family Physicians Group, or FPG, serving Medicare Advantage and Managed Medicaid HMO patients through its senior focused clinics in Greater Orlando, Florida. Also, during 2018, we acquired the remaining equity interest in Miami, Florida based MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Clinical care services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Clinical care services include the operations of Humana At Home, Inc., or Humana At Home ®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. At December 31, 2019, we have enrolled approximately 868,800 members, with complex chronic conditions participating in a Humana Chronic Care Program, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. These members may not be unique to each program since members have the ability to enroll in multiple programs. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

We have committed additional investments in our home care capabilities with our acquisition of a 40% minority interest in Kindred at Home, Inc., or Kindred at Home, and Curo Health Services, or Curo, which combined creates the nation's largest home health and hospice provider with 65% overlap with our individual Medicare Advantage business. See Note 4 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management and wellness programs. These programs use our capabilities that enable us to create a more complete view of an individual’s health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

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

Wellness

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

Our Go365 program provides our members with access to a science-based, actuarially driven wellness and loyalty program that features a wide range of well-being tools and rewards that are customized to an individual’s needs and

wants. A key element of the program includes a sophisticated health-behavior-change model supported by an incentive program.

Our Individual Commercial Segment Products

Our individual health plans were marketed under the HumanaOne brand. We offered products both on and off of the public exchange.

We discontinued substantially all off-exchange individual commercial medical plans effective January 1, 2017, and we exited our remaining individual commercial medical business effective January 1, 2018.

Other Businesses

Other Businesses includes those businesses that do not align with the reportable segments previously described, primarily our closed-block long-term care insurance policies, which were sold in 2018. For a detailed discussion of the sale refer to Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Membership

The following table summarizes our total medical membership at December 31,2019, by market and product:

	Retail Segment				Group and Specialty Segment					
	(in thousands)									
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Total	Percent of Total
Florida	701.4	10.2	188.6	16.5	460.9	145.4	36.9	—	1,559.9	9.4%
Texas	285.9	244.5	292.3	19.5	—	140.8	31.0	—	1,014.0	6.1%
Kentucky	98.0	65.6	201.4	6.1	—	106.6	135.3	—	613.0	3.7%
California	83.9	0.7	436.7	20.7	—	—	—	—	542.0	3.3%
Georgia	144.4	2.0	113.3	11.4	—	135.6	71.3	—	478.0	2.9%
Illinois	126.2	25.0	172.0	7.7	8.1	36.8	76.7	—	452.5	2.7%
Ohio	150.3	23.3	153.2	42.8	—	33.0	31.4	—	434.0	2.6%
Missouri/Kansas	98.1	4.8	189.0	12.1	—	38.9	26.0	—	368.9	2.2%
North Carolina	179.2	0.4	148.6	6.5	—	—	—	—	334.7	2.0%
Tennessee	153.9	4.9	104.8	7.0	—	38.3	14.0	—	322.9	1.9%
Louisiana	167.3	13.8	55.5	3.1	—	52.7	19.4	—	311.8	1.9%
Wisconsin	63.5	5.7	104.6	7.0	—	65.9	32.9	—	279.6	1.7%
Indiana	113.9	7.1	121.9	10.2	—	19.3	11.8	—	284.2	1.7%
Virginia	132.2	3.8	139.5	9.2	—	—	—	—	284.7	1.7%
Michigan	70.9	18.9	118.7	4.7	—	1.8	—	—	215.0	1.3%
Arizona	92.8	0.4	88.0	7.4	—	21.5	8.1	—	218.2	1.3%
Pennsylvania	56.6	2.2	139.4	5.6	—	—	—	—	203.8	1.1%
South Carolina	99.4	0.5	59.0	5.9	—	—	—	—	164.8	1.0%
Military services	—	—	—	—	—	—	—	5,984.3	5,984.3	35.9%
Others	769.3	91.5	1,538.7	95.0	—	72.0	34.4	—	2,600.9	15.6%
Totals	3,587.2	525.3	4,365.2	298.4	469.0	908.6	529.2	5,984.3	16,667.2	100.0%

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers whom we employ or with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care providers, specialist physicians, dentists, and providers of ancillary health care services

and facilities. These ancillary services and facilities include laboratories, ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

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

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

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

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

Capitation

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

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

At December 31, 2019, approximately 1,289,100 members, or 7.7% of our medical membership, were covered under risk-based contracts, which provide all member benefits, including 1,116,000 individual Medicare Advantage members, or 31.1% 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 203,800 HMO members, including 196,300 individual Medicare Advantage members, or 17.6% of the 1,116,000 individual Medicare Advantage members covered under risk-based contracts at December 31, 2019, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $1.9 billion, or 3.6% of total benefits expense, for the year ended December 31,2019. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

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

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

Recredentialing of participating providers occurs every three years, unless otherwise required by state or federal regulations. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee composed of a peer group of providers reviews the applications of providers being considered for credentialing and recredentialing.

We maintain accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), and/or URAC. Certain commercial businesses, such as those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, population health management, credentialing, utilization management, network management, and member experience. We have achieved and maintained NCQA accreditation in many of our commercial, Medicare and Medicaid HMO/POS and PPO markets and our wellness program, Go365. Humana's pharmacy organization is accredited by URAC.

Sales and Marketing

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

At December 31, 2019, we employed approximately 1,400 sales representatives, as well as approximately 1,400 telemarketing representatives who assisted in the marketing of Medicare, including Medicare Advantage and PDP, in our Retail segment and specialty products in our Group and Specialty segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular

customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group and Specialty segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. We use licensed independent brokers, independent agents, digital insurance agencies, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our specialty products.

Underwriting

Since 2014, the Patient Protection and Affordability Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Health Care Reform Law, requires certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2019 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system, including the Health Care Reform Law.

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

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this2019 Form 10-K.

Certain Other Services

Captive Insurance Company

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

Centralized Management Services

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

Employees

As of December 31, 2019, we had approximately 46,000 employees and approximately 1,200 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.

Information About Our Executive Officers

Set forth below are names and ages of all of our current executive officers as of February 1, 2020, their positions, and the date first elected as an officer.

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	57	President and Chief Executive Officer, Director	12/11	(1)
Vishal Agrawal, M.D.	45	Chief Strategy and Corporate Development Officer	12/18	(2)
Heather M. Carroll Cox	49	Chief Digital Health and Analytics Officer	08/18	(3)
Sam M. Deshpande	55	Chief Technology and Risk Officer	07/17	(4)
Susan M. Diamond	46	Segment President, Home Business	07/19	(5)
William K. Fleming, PharmD	52	Segment President, Clinical and Pharmacy Solutions	03/17	(6)
Christopher H. Hunter	51	Segment President, Group and Military Business	01/14	(7)
Timothy S. Huval	53	Chief Administrative Officer	12/12	(8)
Brian A. Kane	47	Chief Financial Officer	06/14	(9)
William H. Shrank, M.D., MSHS	48	Chief Medical and Corporate Affairs Officer	04/19	(10)
Joseph C. Ventura	43	Chief Legal Officer	02/19	(11)
T. Alan Wheatley	52	Segment President, Retail	03/17	(12)
Cynthia H. Zipperle	57	Senior Vice President, Chief Accounting Officer and Controller	12/14	(13)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Dr. Agrawal currently serves as Chief Strategy and Corporate Development Officer, having joined the company in December 2018. Prior to joining the company, Dr. Agrawal was Senior Advisor for The Carlyle Group L.P., having held that position from October 2017 to December 2018. Previously, Dr. Agrawal was President and Chief Growth Officer of Ciox Health, the largest health information exchange and release of information services organization in the U.S. from December of 2015 to October 2018. Prior to joining Ciox Health, Dr. Agrawal served as President of Harris Healthcare Solutions from January 2013 to December 2015.

(3) Ms. Cox currently serves as Chief Digital Health and Analytics Officer, having joined the Company in August 2018. Prior to joining the Company, Ms. Cox served as Chief Technology and Digital Officer at USAA, where she led the teams responsible for designing and building personalized and digitally-enabled end-to-end experiences for USAA members. Prior to USAA, Heather was the CEO of Citi FinTech at Citigroup, Inc., helping the company adapt to a future dominated by mobile technology, and she headed Card Operations, reshaping customer and digital experience for Capital One.

(4) Mr. Deshpande currently serves as Chief Technology and Risk Officer, having been elected to this position in August 2019, from his prior role as Chief Risk Officer. Before joining Humana in July 2017, Mr. Deshpande spent 17 years at Capital One in key leadership positions, most recently as Business Chief Risk Officer for the U.S. and international card business. He previously served as the Business Chief Risk Officer and Head of Enterprise Services for the Financial Services Division, responsible for Business Risk, Data Science, Data Quality, Process Excellence and Project Management. He also led marketing and analysis for the Home Loans, Auto Finance, and Credit Card businesses, with responsibilities for business strategy, credit, product and marketing.

(5) Susan M. Diamond currently serves as Segment President, Home Business, having been elected to this position in July 2019. Ms. Diamond joined the Company in June 2004 and has spent the majority of her Humana career in various leadership roles in the Medicare business, with a particular passion and emphasis on growth and consumer segmentation strategies for the Company's Individual Medicare Advantage and Stand Alone Part D offerings. Ms. Diamond also served for two and a half years as the Enterprise Vice President of Finance, where she was responsible for enterprise planning and forecasting, trend analytics and had responsibility for each of the Company's line of business CFOs and controllers.

(6) Dr. Fleming currently serves as Segment President, Clinical and Pharmacy Solutions, where he is responsible for Humana's Clinical Solutions (strategy, quality, trend, and operations), Pharmacy Solutions (PBM, mail, specialty, retail), and Enterprise Clinical Operating Model, having held this position since December 2019. Prior to that, Dr. Fleming held positions of Segment President, Healthcare Services as well as President of the Company's pharmacy business. Dr. Fleming joined the Company in 1994.

(7) Mr. Hunter currently serves as Segment President, Group and Military Business, having been elected to this position in August 2018 after having previously served as the Company's Chief Strategy Officer since January 2014. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(8) Mr. Huval currently serves as Chief Administrative Officer, having been elected to this position in July 2019, from his previous role as Chief Human Resources Officer. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(9) Mr. Kane currently serves as Chief Financial Officer, having been elected to this position in June 2014. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(10) Dr. Shrank currently serves as Chief Medical and Corporate Affairs Officer, having been elected to this position in July 2019, from his previous role as Chief Medical Officer. Before joining Humana in April 2019, Dr. Shrank served as Chief Medical Officer, Insurance Services Division at the University of Pittsburgh Medical Center, from 2016-2019, where he oversaw approximately $9 billion in annual health care expenditures for approximately 3.5 million members in Medicare, Medicaid, behavioral health, Managed Long Term Social Supports and commercial lines of business. He also developed and evaluated population health programs to further advance the medical center's mission as an integrated delivery and financing system. Prior to that, Dr. Shrank served as Senior Vice President, Chief Scientific Officer, and Chief Medical Officer of Provider Innovation at CVS Health from 2013 to 2016. Prior to joining CVS Health, Dr. Shrank served as Director, Research and Rapid-Cycle Evaluation Group, for the Center for Medicare and Medicaid Innovation, part of CMS from 2011 to 2013, where he led the evaluation of all payment and health system delivery reform programs and developed the rapid-cycle strategy to promote continuous quality improvement. Dr. Shrank began his career as a practicing physician with Brigham and Women's Hospital in Boston and as an Assistant Professor at Harvard

Medical School. His research at Harvard focused on improving the quality of prescribing and the use of chronic medications. He has published more than 200 papers on these topics.

(11) Mr. Ventura currently serves as Chief Legal Officer. He joined the Company in January 2009 and since then has held various positions of increasing responsibility in the Company's Law Department, including most recently, Senior Vice President, Associate General Counsel & Corporate Secretary from July 2017 until February 2019.

(12) Mr. Wheatley currently serves as Segment President, Retail, having held this position since March 2017. During his 25-year career with the Company, Mr. Wheatley has served in a number of key leadership roles, including Vice President of Medicare Service Operations and President of the East Region, one of the Company's key Medicare geographies.

(13) Mrs. Zipperle currently serves as Senior Vice President, Chief Accounting Officer and Controller, having held this position since December 2014. Mrs. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

ITEM 1A. RISK FACTORS

Risks Relating to Our Business

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

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

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

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to

appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

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

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

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

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

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

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

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

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

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 82% of our total premiums and services revenue for the year ended December 31,2019 generated from our Medicare products, including15% 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 achievement of Star ratings of 4-Star or higher qualifies Medicare Advantage plans for premium bonuses. Our Medicare Advantage plans' operating results may be significantly affected by their star ratings. Despite our operational efforts to improve our star ratings, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our Star ratings. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

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

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

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

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

There can be no assurance that our information technology, or IT, process will successfully improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, defend against cybersecurity attacks, or improve service levels. In addition, there can be no assurance that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our

information systems and data, or to defend against cybersecurity attacks, may result in a material adverse effect on our results of operations, financial position, and cash flows.

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

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. We have been, and will likely continue to be, regular targets of attempted cybersecurity attacks and other security threats and may be subject to breaches of our information technology security systems. Although the impact of such attacks has not been material to our operations or results of operations, financial position, or cash flow through December 31, 2019, we can provide no assurance that we will be able to detect, prevent, or contain the effects of such cybersecurity attacks or other information security risks or threats in the future. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our businesses whose operations are subject to similar risks.

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

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

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

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

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;

- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice;
- claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation or non-acceptance or termination of provider contracts;
- disputes related to ASO business, including actions alleging claim administration errors;
- qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model;
- claims related to the failure to disclose some business practices;
- claims relating to customer audits and contract performance;
- claims relating to dispensing of drugs associated with our in-house dispensing pharmacies; 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 17 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 87% of our total premiums and services revenue for the year ended December 31,2019. These programs involve various risks, as described further below.

- At December 31, 2019, under our contracts with CMS we provided health insurance coverage to approximately701,400 individual Medicare Advantage members in Florida. These contracts accounted for approximately 15% of our total premiums and services revenue for the year ended December 31, 2019. 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 or

changes to member eligibility criteria 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, 2019, our military services business, which accounted for approximately1% of our total premiums and services revenue for theyear ended December 31, 2019, primarily consisted of the TRICARE T2017 East Region contract.The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5 -year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option. The loss of the TRICARE T2017 East Region contract may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.
- CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

  CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score was calculated from claims data submitted through EDS. CMS will increase that percentage to 50% in 2020 and has proposed to increase that percentage to75% in 2021. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

  CMS and the Office of the Inspector General of Health and Human Services, or HHS-OIG, are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data.

We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

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

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the “Proposed Rule”) related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We believe that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and have provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial position, or cash flows.

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

We believe that CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS’ final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed

Rule, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

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

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $170 million at December 31, 2019 and 2018.

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

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

- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations, including audits of risk adjustment data, are also conducted by state attorneys general, CMS, HHS-OIG, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of

litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

Our business activities are subject to substantial government regulation. New laws or regulations, or legislative, judicial, or regulatory changes in existing laws or regulations or their manner of application could increase our cost of doing business and 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 by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Health Care Reform Law and Other Current or Future Legislative, Judicial or Regulatory Changes

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. The annual health insurance industry fee was suspended in 2019, but will resume for calendar year 2020, not be deductible for income tax purposes, and significantly increase our effective tax rate. In 2018, the fee levied on the health insurance industry was $14.3 billion. Under current law, the health industry fee will be permanently repealed beginning in calendar year 2021.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative, judicial or regulatory changes, including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage business profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, or increases in regulation of our prescription drug benefit businesses, 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 assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the Health Care Reform Law or declare all or certain portions of the Health Care Reform Law unconstitutional, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes or judicial determinations may occur.

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

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes

administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent.

These regulations set standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

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

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

American Recovery and Reinvestment Act of 2009 (ARRA)

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

Corporate Practice of Medicine and Other Laws

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

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

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

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

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

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

Environmental

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

State Regulation of Insurance-Related Products

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

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

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

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

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

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

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive

disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

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

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

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

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, including manufacturing or other supply issues that could impact the availability of such 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 in-house dispensing

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 in-house dispensing 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

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.

We owned or leased numerous medical centers and administrative offices at December 31, 2019. The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of these medical centers, approximately 185 of these facilities are leased or subleased to our contracted providers to operate.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, qui tam litigation brought by individuals seeking to sue on behalf of the government, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings and Certain Regulatory Matters" in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM.

Holders of our Capital Stock

As of January 31, 2020, there were 2,100 holders of record of our common stock and 229,470 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2018 and 2019, under our Board approved quarterly cash dividend policy:

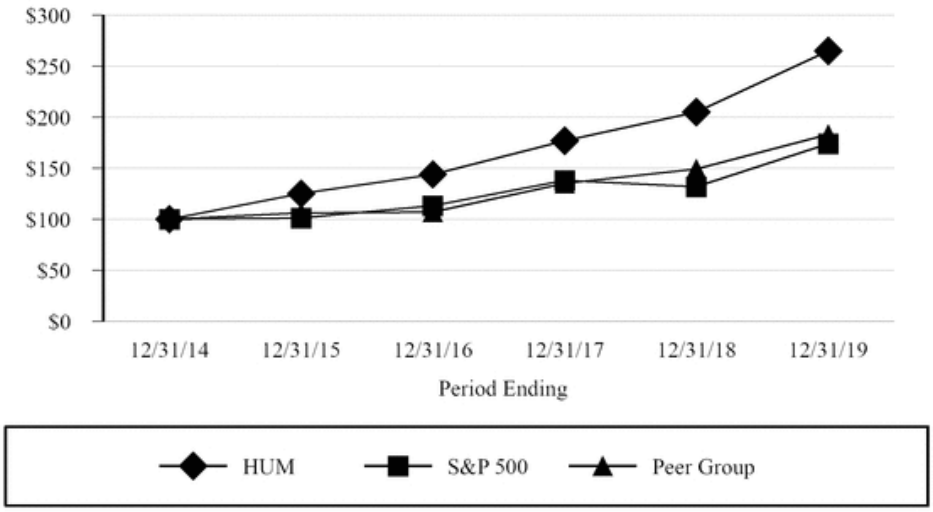
Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2018 payments			
12/29/2017	1/26/2018	$0.40	$55
3/30/2018	4/27/2018	$0.50	$69
6/29/2018	7/27/2018	$0.50	$69
9/28/2018	10/26/2018	$0.50	$69
2019 payments			
12/31/2018	1/25/2019	$0.50	$68
3/29/2019	4/26/2019	$0.55	$74
6/28/2019	7/26/2019	$0.55	$74
9/30/2019	10/25/2019	$0.55	$73

On October 24, 2019, the Board declared a cash dividend of $0.55 per share that was paid on January 31, 2020 to stockholders of record on December 31, 2019, for an aggregate amount of $73 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2020, the Board declared a cash dividend of $0.625 per share payable on April 24, 2020 to stockholders of record on March 31, 2020.

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, 2019. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2014, and that dividends were reinvested when paid.



	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019
HUM	$ 100	$ 125	$ 144	$ 177	$ 205	$ 265
S&P 500	$ 100	$ 101	$ 113	$ 138	$ 132	$ 174
Peer Group	$ 100	$ 106	$ 107	$ 135	$ 149	$ 183

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 31,2019 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1) (2)
October 2019	—	$ —	—	$ 2,000,000,000
November 2019	—	—	—	2,000,000,000
December 2019	—	—	—	2,000,000,000
Total	—	$ —	—	

(1) On July 31, 2019, we entered into an accelerated stock repurchase agreement, the July 2019 ASR, with Citibank, N.A., or Citi, to repurchase $1 billion of our common stock. On August 2, 2019, we made a payment of $1 billion to Citi and received an initial delivery of 2.7 million shares of our common stock. We recorded the payment to Citi as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 2.7 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by Citi pending final settlement of the July 2019 ASR. Upon final settlement of the July 2019 ASR on December 26, 2019, we received an additional 0.7 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $296.19, bringing the total shares received under the July 2019 ASR to 3.4 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by Citi from capital in excess of par value to treasury stock.

(2) Excludes 0.2 million shares repurchased in connection with employee stock plans.

ITEM 6. SELECTED FINANCIAL DATA

	2019	2018	2017 (a)	2016 (b)	2015
	(dollars in millions, except per common share results)				
Summary of Operating Results					
Total revenues	$ 64,888	$ 56,912	$ 53,767	$ 54,379	$ 54,289
Income from operations	3,192	3,100	4,262	1,741	2,347
Loss (gain) on Sale of Business	—	786	—	—	(270)
Interest expense	242	218	242	189	186
Other (income) expense, net	(506)	33	—	—	—
Income before income taxes and equity in net earnings	3,456	2,063	4,020	1,552	2,431
Provision for income taxes	763	391	1,572	938	1,155
Equity in net earnings of Kindred at Home	14	11	—	—	—
Net income	$ 2,707	$ 1,683	$ 2,448	$ 614	$ 1,276
Basic earnings per common share	$ 20.20	$ 12.24	$ 16.94	$ 4.11	$ 8.54
Diluted earnings per common share	$ 20.10	$ 12.16	$ 16.81	$ 4.07	$ 8.44
Dividends declared per common share	$ 2.20	$ 2.00	$ 1.60	$ 1.16	$ 1.15
Financial Position					
Cash and investments	$ 15,432	$ 12,780	$ 16,344	$ 13,675	$ 11,681
Total assets	29,074	25,413	27,178	25,396	24,678
Benefits payable	6,004	4,862	4,668	4,563	4,976
Debt	5,666	6,069	4,920	4,092	4,093
Stockholders' equity	12,037	10,161	9,842	10,685	10,346
Cash flows from operations	$ 5,284	$ 2,173	$ 4,051	$ 1,936	$ 868
Key Financial Indicators					
Benefit ratio	85.6%	83.5%	83.0%	84.9%	84.5%
Operating cost ratio	11.5%	13.3%	12.3%	13.3%	13.6%
Membership					
Total medical membership	16,667,200	16,576,700	14,003,100	14,230,200	14,222,800
Total specialty membership	5,425,900	6,072,300	6,986,000	6,961,200	7,221,800

(a) Included in operating expenses is $936 million (or $4.31 per diluted common stock) associated with the merger termination fee and related costs, net. Under the terms of the Agreement and Plan of Merger with Aetna Inc., and certain wholly owned subsidiaries of Aetna Inc., which we collectively refer to as Aetna, we received a breakup fee of $1 billion from Aetna included in this amount.

(b) Includes a reduction in premiums revenue of $583 million ($367 million after tax, or $2.43 per diluted common share) associated with the write-off of commercial risk corridor receivables. Also includes benefits expense of $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies, which were sold in 2018.

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

For discussion of 2017 items and year-over-year comparisons between 2018 and 2017 that are not included in this 2019 Form 10-K, refer to "Item 7. – Management Discussion and Analysis of Financial Condition and Results of Operations" found in our Form 10-K for the year ended December 31, 2018, that was filed with the Securities and Exchange Commission on February 21, 2019.

Executive Overview

General

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

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

Business Segments

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable 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, the chief operating decision maker, to assess performance and allocate resources. See Note 18 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes our military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes our services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our minority investment in Kindred at Home.

The results of each segment are measured by income before income taxes and equity in net earnings from Kindred at Home, or segment earnings. Transactions between reportable segments primarily consist of sales of services rendered

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

Seasonality

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

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

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

Aetna Merger

On February 16, 2017, under the terms of the Agreement and Plan of Merger, or Merger Agreement, with Aetna Inc., and certain wholly owned subsidiaries of Aetna Inc., which we collectively refer to as Aetna, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned "Merger termination fee and related costs, net."

Acquisitions and Divestitures

In the first quarter of 2020, we acquired privately held Enclara Healthcare, or Enclara, one of the nation's largest hospice pharmacy and benefit management providers for cash consideration of approximately $707 million, net of cash received. The purchase accounting is incomplete due to the timing of the availability of information.

Also in the first quarter of 2020, our Partners in Primary Care wholly-owned subsidiary entered into a strategic partnership with Welsh, Carson, Anderson & Stowe, or WCAS, to accelerate the expansion of our primary care model. The WCAS partnership is expected to open approximately 50 payor-agnostic, senior-focused primary care centers over 3 years beginning in 2020. Partners in Primary Care committed to the acquisition of a non-controlling interest in the approximately $600 million entity. In addition, the agreement includes a series of put and call options through which WCAS may require us to purchase their interest in the entity and, through which we may acquire WCAS's interest over the next 5 - 10 years.

In the third quarter of 2018, we completed the sale of our wholly-owned subsidiary KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, included our closed block of non-strategic commercial long-term care policies. Upon closing, we funded the transaction with

approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale.

Also in the third quarter of 2018, we, along with TPG Capital, or TPG, and WCAS (together, the "Sponsors"), completed the acquisitions of Kindred and Curo, respectively, merging Curo with the hospice business of Kindred at Home. As part of these transactions, we acquired a 40% minority interest in Kindred at Home, a leading home health and hospice company, for total cash consideration of approximately $1.1 billion.

In the second quarter of 2018, we acquired Family Physicians Group, or FPG, for cash consideration of approximately $185 million, net of cash received. FPG is one of the largest at-risk providers serving Medicare Advantage and Managed Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties. The acquisition of FPG advances our strategy of helping physicians and clinicians evolve from treating health episodically to managing health holistically.

In the first quarter of 2018, we acquired the remaining equity interest in MCCI Holdings, LLC, or MCCI, a privately held management service organization headquartered in Miami, Florida, which primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. The purchase price consisted primarily of $169 million cash, as well as our existing investment in MCCI and a note receivable and a revolving note with an aggregate balance of $383 million.

These transactions are more fully discussed in Note 3 and Note 4 to the consolidated financial statements.

Highlights

- Our 2019 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, 2019, approximately 2,407,000 members, or 67%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 2,039,100 members, or 67%, at December 31, 2018. Medicare Advantage and dual demonstration program membership enrolled in a Humana chronic care management program was 868,800 at December 31, 2019, anincrease of 21.3% from 716,000 at December 31, 2018.These members may not be unique to each program since members have the ability to enroll in multiple programs. The increase is driven by our improved process for identifying and enrolling members in the appropriate program at the right time, coupled with growth in Special Needs Plans, or SNP, membership.

- On February 5, 2020, after the stock market closed, the Centers for Medicare and Medicaid Services (“CMS”) issued Part II of the 2021 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the “Advance Notice”). CMS has invited public comment on the Advance Notice before publishing final rates on April 6, 2020 (the “Final Notice”).

  In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 0.93 percent increase in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee-for-service county rebasing/repricing because the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. Based on our preliminary analysis using the same factors CMS included in its estimate, the components of

which are detailed on CMS' website, we anticipate that the proposals in the Advance Notice would result in a change to our benchmark funding relatively in line with CMS' estimate.

Also on February 5, 2020, CMS issued a proposed rule (which we refer to as the "2021 Proposed Rule") related to the administration of the MA and Part D programs, including, among other things, the Agency's implementation of recent legislation removing the limitation on MA eligibility for end-stage-renal-disease, or ESRD, Medicare-eligible beneficiaries beginning in 2021, allowing for Medicare Advantage plans to offer additional supplemental benefits including telehealth, and addressing opioid recovery and treatment. The 2021 Proposed Rule also recognizes the potential opportunity to create new options for beneficiaries, including ESRD beneficiaries, and their access to care through greater flexibility around current network adequacy requirements. CMS has invited public comments to the 2021 Proposed Rule on or before April 6, 2020.

The Advance Notice and the 2021 Proposed Rule are subject to the required notice and comment period, and we cannot predict when or to what extent CMS will adopt the proposals in the Advance Notice or the 2021 Proposed Rule. We will be drawing upon our program expertise to provide CMS formal commentary on the impact of both the Advance Notice and the 2021 Proposed Rule and the related impact upon Medicare beneficiaries' quality of care and service to our members through the MA and Part D programs.

- Net income was $2.7 billion for 2019 compared to $1.7 billion in 2018 and earnings per diluted common share increased $7.94 from $12.16 earnings per diluted common share in 2018 to $20.10 earnings per diluted common share in 2019. This comparison was primarily impacted by higher segment earnings in our Retail and Healthcare Services segments, partially offset by lower Group and Specialty segment earnings. These changes were further favorably impacted by the put/call valuation adjustments associated with our investment in Kindred at Home and by a lower number of shares used to compute dilutive earnings per share, primarily reflecting share repurchases. In addition, year-over-year comparison to 2019 was impacted by the loss on the sale of KMG of $786 million recognized in 2018.

- Contributing to our Retail segment revenue growth was our individual and group Medicare Advantage membership, which increased 550,700 members, or 15.5%, from 3,561,800 members at December 31, 2018 to 4,112,500 members at December 31, 2019.

- Our operating cash flow of $5.3 billion for 2019 improved from $2.2 billion for 2018, reflecting the significant impact of increasing premiums and enrollment, as premiums generally are collected in advance of claim payments by a period of up to several months. The year-over-year comparison was further impacted by the timing of other working capital changes, higher earnings in 2019 versus 2018, and the negative impact on 2018 cash flows resulting from the funding of reinsurance transactions in connection with the sale of KMG.

- In July 2019, the Board of Directors approved a $3.0 billion share repurchase authorization with an expiration date of June 30, 2022. We subsequently entered into an agreement with a third-party financial institution on July 31, 2019, to effect a $1.0 billion ASR program under the authorization. Under the terms of this program, which was completed in the fourth quarter of 2019, we repurchased approximately 3,376,200 shares at an average price, after a discount, of $296.19. Aside from the completion of the ASR program, we have not completed any open market stock repurchases. As of February 19, 2020, we had a remaining repurchase authorization of $2.0 billion.

- In August 2019, we issued $500 million of 3.125% senior notes due August 15, 2029, and $500 million of 3.950% senior notes due August 15, 2049. Our net proceeds, reduced for the underwriters discount and commission and offering expenses, were $987 million. We used the net proceeds from this offering, together with available cash, to repay the $650 million outstanding amount due under our term note in August 2019, and the $400 million aggregate principal amount of our 2.625% senior notes due on its maturity date of October 1, 2019.

- In 2019 we initiated an involuntary workforce optimization program that will allow us to promote operational excellence, accelerate our strategy, fund critical initiatives and advance our growth objectives. As a result we recorded estimated charges of $47 million, or $0.26 per diluted common share, on the corporate level, included

with operating costs in the condensed consolidated statements of income. We expect this liability to be primarily paid within 12 months.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee was suspended in 2019, but will resume for calendar year 2020, not be deductible for income tax purposes, and significantly increase our effective tax rate. In 2018, the fee levied on the health insurance industry was $14.3 billion. Under current law, the health industry fee will be permanently repealed beginning in calendar year 2021.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative, judicial or regulatory changes, including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, or increases in regulation of our prescription drug benefit businesses, 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 assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail and Group and Specialty segment customers and are described in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data in this 2019 Form 10-K.

Comparison of Results of Operations for 2019 and 2018

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31,2019 and 2018:

Consolidated

			Change	
	2019	2018	Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 56,254	$ 48,108	$ 8,146	16.9 %
Group and Specialty	6,694	6,803	(109)	(1.6)%
Individual Commercial	—	8	(8)	(100.0)%
Other Businesses	—	22	(22)	(100.0)%
Total premiums	62,948	54,941	8,007	14.6 %
Services:				
Retail	17	11	6	54.5 %
Group and Specialty	790	835	(45)	(5.4)%
Healthcare Services	632	607	25	4.1 %
Other Businesses	—	4	(4)	(100.0)%
Total services	1,439	1,457	(18)	(1.2)%
Investment income	501	514	(13)	(2.5)%
Total revenues	64,888	56,912	7,976	14.0 %
Operating expenses:				
Benefits	53,857	45,882	7,975	17.4 %
Operating costs	7,381	7,525	(144)	(1.9)%
Depreciation and amortization	458	405	53	13.1 %
Total operating expenses	61,696	53,812	7,884	14.7 %
Income from operations	3,192	3,100	92	3.0 %
Loss on sale of business	—	786	(786)	(100.0)%
Interest expense	242	218	24	11.0 %
Other (income) expense, net	(506)	33	(539)	(1633.3)%
Income before income taxes and equity in net earnings	3,456	2,063	1,393	67.5 %
Provision for income taxes	763	391	372	95.1 %
Equity in net earnings of Kindred at Home	14	11	3	27.3 %
Net income	$ 2,707	$ 1,683	$ 1,024	60.8 %
Diluted earnings per common share	$ 20.10	$ 12.16	$ 7.94	65.3 %
Benefit ratio (a)	85.6%	83.5%		2.1 %
Operating cost ratio (b)	11.5%	13.3%		(1.8)%
Effective tax rate	22.0%	18.9%		3.1 %

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

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

Summary

Net income for 2019 was $2.7 billion, or $20.10 per diluted common share, compared to $1.7 billion, or $12.16 per diluted common share, in 2018. This increase primarily was impacted by our Medicare Advantage business and Healthcare Services segment, as well as by previously implemented productivity initiatives that led to significant operating cost efficiencies in 2019. These impacts were partially offset by strategic investments in our integrated care delivery model, the impact of higher compensation accruals for the Annual Incentive Plan, or AIP, offered to employees across all levels of the company, lower Group and Specialty segment earnings, increased spending associated with the 2020 Medicare Annual Election Period, or AEP, and the impact of workforce optimization. These changes were further favorably impacted by the put/call valuation adjustments associated with our investment in Kindred at Home and by a lower number of shares used to compute dilutive earnings per share, primarily reflecting share repurchases. In addition, 2019 was impacted by the loss on the sale of KMG recognized in 2018.

Premiums Revenue

Consolidated premiums increased $8.0 billion, or 14.6%, from $54.9 billion for 2018 to $62.9 billion for 2019 primarily due to higher premiums in the Retail segment, driven by higher premium revenues from our Medicare Advantage business resulting from membership growth and higher per member premiums associated with individual Medicare Advantage. These increases were partially offset by the impact of declining stand-alone PDP membership, as well as lower premiums in the Group and Specialty segment as discussed in the detailed segment results discussion that follows.

Services Revenue

Consolidated services revenue decreased $18 million, or 1.2%, from $1.5 billion for 2018 to $1.4 billion for 2019, primarily due to a decrease in services revenue in the Group and Specialty segment, partially offset by an increase in the Healthcare Services segment as detailed in the segment results discussion that follows.

Investment Income

Investment income was $501 million for 2019, decreasing $13 million, or 2.5%, from 2018, primarily due to lower realized capital gains, partially offset by higher average invested balances and interest rates.

Benefits Expense

Consolidated benefits expense was $53.9 billion for 2019, an increase of $8.0 billion, or 17.4%, from 2018 reflecting an increase in the Retail and Group and Specialty segments benefits expense as discussed in the detailed segment results discussion that follows. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $336 million in 2019 and $503 million in 2018.

The consolidated benefit ratio for 2019 was 85.6%, an increase of 210 basis points from 2018 primarily due to the suspension of the health insurance industry fee in 2019, which was contemplated in the pricing and benefit design of our products, lower favorable prior-period medical claims reserve development, an increase in the Group and Specialty benefit ratio as discussed in the detailed segment results discussion that follows, and the shift in Medicare membership mix due to the loss of stand-alone PDP members and significant growth in Medicare Advantage members. These increases were partially offset by engaging our Medicare Advantage members in clinical programs, as well as ensuring they are appropriately documented under the CMS risk-adjustment model, and lower than expected medical costs as compared to the assumptions used in the pricing of our individual Medicare Advantage business for 2019. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 50 basis points in 2019 and 90 basis points in 2018.

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 $144 million, or 1.9%, from 2018 to $7.4 billion in 2019 reflecting a decrease in operating costs in the Retail and the Group and Specialty segments as discussed in the detailed segment results discussion that follows.

The consolidated operating cost ratio for 2019 was 11.5%, decreasing 180 basis points from 13.3% in 2018 primarily due to the suspension of the health insurance industry fee in 2019, scale efficiencies associated with growth in our Medicare Advantage membership, and significant operating cost efficiencies in 2019 driven by previously implemented productivity initiatives. These improvements were partially offset by strategic investments in our integrated care delivery model, the impact of higher compensation expense accruals in 2019 for the AIP offered to employees across all levels, increased spending associated with the Medicare AEP, and charges associated with workforce optimization. The higher compensation accruals resulted from our continued strong performance, including customer satisfaction as measured by the net promoter score, along with higher than anticipated individual Medicare Advantage membership growth. The nondeductible health insurance industry fee impacted the operating cost ratio by approximately 180 basis points in 2018.

Depreciation and Amortization

Depreciation and amortization in 2019 totaled $458 million compared to $405 million in 2018, an increase of 13.1%, primarily due to capital expenditures.

Interest Expense

Interest expense was $242 million for 2019 compared to $218 million for 2018, an increase of $24 million, or 11.0% The increase was primarily due to the higher average borrowings outstanding including the impact of the borrowings under the November 2018 term loan agreement and senior notes issued in August 2019.

Income Taxes

Our effective tax rate during 2019 was 22.0% compared to the effective tax rate of 18.9% in 2018. This change primarily reflects the impact of the suspension of the non-deductible health insurance industry fee in 2019 as well as the deferred tax benefit recognized in 2018 from the loss on sale of KMG. The effective income tax rate in 2018 reflected a $430 million deferred tax benefit, resulting from the loss on the sale of KMG attributable to its original tax basis and subsequent capital contributions to fund accumulated losses. See Note 12 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

			Change	
	2019	2018	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	3,587,200	3,064,000	523,200	17.1 %
Group Medicare Advantage	525,300	497,800	27,500	5.5 %
Medicare stand-alone PDP	4,365,200	5,004,300	(639,100)	(12.8)%
Total Retail Medicare	8,477,700	8,566,100	(88,400)	(1.0)%
State-based Medicaid	469,000	341,100	127,900	37.5 %
Medicare Supplement	298,400	254,300	44,100	17.3 %
Total Retail medical members	9,245,100	9,161,500	83,600	0.9 %

	2019	2018	Change Dollars	Change Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 43,128	$ 35,656	$ 7,472	21.0 %
Group Medicare Advantage	6,475	6,103	372	6.1 %
Medicare stand-alone PDP	3,165	3,584	(419)	(11.7)%
Total Retail Medicare	52,768	45,343	7,425	16.4 %
State-based Medicaid	2,898	2,255	643	28.5 %
Medicare Supplement	588	510	78	15.3 %
Total premiums	56,254	48,108	8,146	16.9 %
Services	17	11	6	54.5 %
Total premiums and services revenue	$ 56,271	$ 48,119	$ 8,152	16.9 %
Segment earnings	$ 2,235	$ 1,733	$ 502	29.0 %
Benefit ratio	86.4%	85.1%		1.3 %
Operating cost ratio	9.4%	11.1%		(1.7)%

Segment Earnings

- Retail segment earnings were $2.2 billion in 2019, an increase of $502 million, or 29.0%, compared to $1.7 billion in 2018 primarily reflecting a lower operating cost ratio, partially offset by the higher benefit ratio as more fully described below. As expected, the higher-than-anticipated individual Medicare Advantage membership growth during the previous AEP had a muted impact on the segment's earnings in 2019. While new Medicare Advantage members increase revenue, on average, they have a break even impact on segment earnings in the first year as they were not previously engaged in clinical programs or appropriately documented under the CMS risk adjustment model, and accordingly, carry a higher benefit ratio.

Enrollment

- Individual Medicare Advantage membership increased 523,200 members, or 17.1%, from 3,064,000 members as of December 31, 2018 to 3,587,200 members as of December 31, 2019, primarily due to membership additions associated with the 2019 AEP and Open Election Period, or OEP, for Medicare beneficiaries. The OEP sales period, which ran from January 1 to March 31, added approximately 43,700 members. Since the conclusion of the OEP, enrollment continued to increase due to strong sales to age-ins and those eligible for Dual Eligible Special Need Plans, or D-SNP. Individual Medicare Advantage membership includes 288,200 D-SNP members as of December 31, 2019, a net increase of 69,600, or 31.8%, from 218,600 December 31, 2018. For the full year 2020, we anticipate a net membership increase in our Individual Medicare Advantage offerings of 270,000 members to 330,000 members.

- Group Medicare Advantage membership increased 27,500 members, or 5.5%, from 497,800 members as of December 31, 2018 to 525,300 members as of December 31, 2019, primarily due to net membership additions associated with the 2019 AEP for Medicare beneficiaries. For the full year 2020, we anticipate a net membership increase in our Group Medicare Advantage offerings of approximately 90,000 members.

- Medicare stand-alone PDP membership decreased 639,100 members, or 12.8%, from 5,004,300 members as of December 31, 2018 to 4,365,200 members as of December 31, 2019, primarily reflecting net declines during the 2019 AEP for Medicare beneficiaries. The anticipated decline primarily was due to the competitive nature of the industry and the pricing discipline we have employed, which resulted in us no longer being the low cost plan in any market for 2019. For the full year 2020, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of approximately 550,000 members.

- State-based Medicaid membership increased 127,900 members, or 37.5%, from 341,100 members as of December 31, 2018 to 469,000 members as of December 31, 2019, primarily driven by the statewide award of a comprehensive contract under the Managed Medical Assistance, or MMA, program in Florida. Our January 31, 2020 state-based contracts membership was 608,000, representing growth of 139,000, or 30%, from December 31, 2019. This growth primarily reflects the impact of terminating the reinsurance agreement with CareSource effective January 1, 2020, which ceded all risk for our Kentucky Medicaid contract.

Premiums revenue

- Retail segment premiums increased $8.1 billion, or 16.9%, from 2018 to 2019 period primarily due to Medicare Advantage membership growth and higher per member premiums, as well as increased state-based contracts membership. These favorable items were partially offset by the decline in membership in our stand-alone PDP offerings.

Benefits expense

- The Retail segment benefit ratio of 86.4% for 2019 increased 130 basis points from 85.1% in 2018 primarily due to the suspension of the health insurance industry fee in 2019 which was contemplated in the pricing and benefit design of our products, lower favorable prior-period medical claims reserve development, as well as the shift in Medicare membership mix due to the loss of stand-alone PDP members and the significant growth in Medicare Advantage members. These increases were partially offset by engaging our Medicare Advantage members in clinical programs as well as ensuring they are appropriately documented under the CMS risk adjustment model, lower than expected medical costs as compared to the assumptions used in the pricing of our individual Medicare Advantage business for 2019, and the impact of a less severe flu season experienced in the first quarter of 2019 compared to that in the first quarter of 2018.

- The Retail segment's benefits expense for 2019 included the beneficial effect of $386 million in favorable prior-year medical claims reserve development versus $398 million in 2018. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 70 basis points in 2019 versus approximately 80 basis points in 2018.

Operating costs

- The Retail segment operating cost ratio of 9.4% for 2019 decreased 170 basis points from 11.1% in 2018 primarily due to the suspension of the health insurance industry fee in 2019, as well as scale efficiencies associated with growth in our Medicare Advantage membership, and significant operating cost efficiencies in 2019 driven by previously implemented productivity initiatives. These improvements were partially offset by the strategic investments in our integrated care delivery model, the impact of higher compensation expense accruals in 2019 for the AIP as a result of our continued strong performance, and increased spending associated with the Medicare AEP.

- The non-deductible health insurance industry fee increased the operating cost ratio by approximately 190 basis points in 2018.

Group and Specialty Segment

	2019	2018	Change Members	Change Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	908,600	1,004,700	(96,100)	(9.6)%
ASO	529,200	481,900	47,300	9.8 %
Military services	5,984,300	5,928,600	55,700	0.9 %
Total group medical members	7,422,100	7,415,200	6,900	0.1 %
Specialty membership (a)	5,425,900	6,072,300	(646,400)	(10.6)%

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

	2019	2018	Change Dollars	Change Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,123	$ 5,444	$ (321)	(5.9)%
Specialty	1,571	1,359	212	15.6 %
Total premiums	6,694	6,803	(109)	(1.6)%
Services	790	835	(45)	(5.4)%
Total premiums and services revenue	$ 7,484	$ 7,638	$ (154)	(2.0)%
Segment earnings	$ 28	$ 361	$ (333)	(92.2)%
Benefit ratio	86.0%	79.7%		6.3 %
Operating cost ratio	22.0%	23.6%		(1.6)%

Segment Earnings

- Group and Specialty segment earnings were $28 million in 2019, a decrease of $333 million, or 92.2%, from $361 million in 2018 primarily due to a higher benefit ratio, along with lower military services business earnings. Earnings comparisons related to the military services business were unfavorably impacted by the receipt of certain contractual incentives and adjustments in 2018 related to the previous TRICARE contract which did not recur in 2019. These decreases were partially offset by the improvement in the operating cost ratio as more fully described below.

Enrollment

- Fully-insured commercial group medical membership decreased 96,100 members, or 9.6% from 1,004,700 members as of December 31, 2018 primarily reflecting lower membership in small group accounts due in part to more small group accounts selecting level-funded ASO products in 2019, as well as the loss of certain large group accounts due to the competitive pricing environment. The portion of group fully-insured commercial medical membership in small group accounts was approximately 59% at December 31, 2019 and 61% at December 31, 2018.
- Group ASO commercial medical membership increased 47,300 members, or 9.8%, from 481,900 members as of December 31, 2018 to 529,200 members as of December 31, 2019 reflecting more small group accounts selecting level-funded ASO products in 2019, partially offset by the loss of certain large group accounts as a

result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.

- Military services membership increased 55,700 members, or 0.9%, from 5,928,600 members as of December 31, 2018 to 5,984,300 members as of December 31, 2019. Membership includes military service members, retirees, and their families to whom we provide healthcare services under the current T2017 TRICARE East Region contract. The current contract, which covers thirty-two states, became effective on January 1, 2018.

- Specialty membership decreased 646,400 members, or 10.6%, from 6,072,300 as of December 31, 2018 to 5,425,900 members as of December 31, 2019 primarily due to the loss of certain group accounts, including one jumbo account, offering stand-alone dental and vision products.

Premiums revenue

- Group and Specialty segment premiums decreased $109 million, or 1.6%, from $6.8 billion in 2018 to $6.7 billion in 2019, primarily due to a decline in our fully-insured group commercial and specialty membership as well as the exit of our voluntary benefit and financial protection products in connection with the sale of KMG in 2018. These decreases were partially offset by higher stop-loss revenues related to our level-funded ASO accounts resulting from membership growth in this product and higher per member premiums across the fully-insured business.

Services revenue

- Group and Specialty segment services revenue decreased $45 million, or 5.4%, from 2018 to 2019 primarily due to the impact of certain contractual incentives and adjustments related to the previous TRICARE contract received in 2018, which did not recur in 2019.

Benefits expense

- The Group and Specialty segment benefit ratio increased 630 basis points from 79.7% in 2018 to 86.0% in 2019 primarily due to the impact of the continued migration of fully-insured group members to level-funded ASO products in 2019 resulting in a membership mix transformation, the suspension of the health insurance industry fee in 2019 which was contemplated in the pricing and benefit design of our products, and unfavorable prior-year medical claims reserve development driven by provider settlements. The benefit ratio was further negatively impacted by adjustments to dental network contracted rates resulting from dental network recontracting and expansion to position the business for the future.

- The Group and Specialty segment's benefits expense included the unfavorable effect of $50 million in prior-year medical claims reserve development in 2019 versus the beneficial effect of $46 million in favorable prior-year medical claims reserve development in 2018. This unfavorable prior-year medical claims reserve development increased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2019 while the favorable prior-year medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2018.

Operating costs

- The Group and Specialty segment operating cost ratio of 22.0% for 2019 decreased 160 basis points from 23.6% for 2018, primarily due to the suspension of the health insurance industry fee in 2019, significant operating cost efficiencies in 2019 driven by previously implemented productivity initiatives, as well as the exit of our voluntary benefit and financial protection products in connection with the sale of KMG in 2018, which carried a higher operating cost ratio. These improvements were offset by the higher compensation expense accruals in 2019 for the AIP as a result of our continued strong consolidated performance.

- The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2018.

Healthcare Services Segment

	2019	2018	Change	
			Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$ 140	$ 176	$ (36)	(20.5)%
Pharmacy solutions	186	203	(17)	(8.4)%
Provider services	306	228	78	34.2 %
Total services revenues	632	607	25	4.1 %
Intersegment revenues:				
Pharmacy solutions	22,189	20,514	1,675	8.2 %
Provider services	2,344	1,994	350	17.6 %
Clinical care services	616	662	(46)	(6.9)%
Total intersegment revenues	25,149	23,170	1,979	8.5 %
Total services and intersegment revenues	$ 25,781	23,777	$ 2,004	8.4 %
Segment earnings	$ 789	$ 754	$ 35	4.6 %
Operating cost ratio	96.4%	96.3%		0.1 %

Segment Earnings

- Healthcare Services segment earnings were $789 million in 2019, an increase of $35 million, or 4.6%, from 2018. This increase primarily was due to higher earnings from our pharmacy operations and clinical operations, and higher earnings from Kindred at Home operations. These factors were partially offset by additional investments in new clinical assets associated with our provider services business.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 456 million in 2019, up 3.6% versus scripts of approximately 440 million in 2018. The increase primarily reflects growth associated with higher Medicare Advantage and state-based contracts membership, partially offset by the decline in stand-alone PDP membership.

Services revenue

- Services revenue increased $25 million, or 4.1%, from 2018 to $632 million for 2019 primarily due to revenue growth from our provider services business.

Intersegment revenues

- Intersegment revenues increased $1.98 billion, or 8.5%, from 2018 to $25 billion for 2019 primarily due to strong Medicare Advantage membership growth, partially offset by the loss of intersegment revenues associated with the decline in stand-alone PDP membership. Intersegment revenues in 2019 were further impacted by higher revenues associated with our provider services business reflecting the previously disclosed acquisitions of MCCI and FPG.

Operating costs

- The Healthcare Services segment operating cost ratio of 96.4% for 2019 was relatively unchanged from 96.3% for 2018.

Liquidity

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

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this2019 Form 10-K.

Cash and cash equivalents increased to $4.1 billion at December 31, 2019 from $2.3 billion at December 31, 2018. The change in cash and cash equivalents for the years ended December 31, 2019, 2018 and 2017 is summarized as follows:

	2019	2018	2017
		(in millions)	
Net cash provided by operating activities	$ 5,284	$ 2,173	$ 4,051
Net cash used in investing activities	(1,278)	(3,087)	(2,941)
Net cash used in financing activities	(2,295)	(785)	(945)
Increase (decrease) in cash and cash equivalents	$ 1,711	$ (1,699)	$ 165

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in the timing of working capital items, earnings, and enrollment activity as discussed below. The increase in operating cash flows in 2019 reflect the significant impacts of increasing premiums and enrollment, as premiums generally are collected in advance of claim payments by a period of up to several months, higher earnings, the timing of other working capital items, and the impact of an approximately $245 million payment related to reinsuring certain voluntary benefit and financial protection products to a third party in connection with the sale of KMG in 2018.

The decrease in operating cash flows in 2018 primarily was due to the receipt of the merger termination fee in 2017, net of related expenses and taxes paid, funding the reinsurance of certain voluntary benefit and financial protection products to a third party in connection with the sale of KMG in 2018 and the timing of working capital items.

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

The detail of benefits payable was as follows at December 31,2019, 2018 and 2017:

				Change	
	2019	2018	2017	2019	2018
			(in millions)		
IBNR (1)	$ 4,150	$ 3,361	$ 3,154	$ 789	$ 207
Reported claims in process (2)	628	617	614	11	3
Other benefits payable (3)	1,226	884	900	342	(16)
Total benefits payable	$ 6,004	$ 4,862	$ 4,668	1,142	194
Payables from disposition					58
Change in benefits payable per cash flow statement resulting in cash from operations				$ 1,142	$ 252

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

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

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

The increase in benefits payable in 2019 and 2018 was primarily due to an increase in IBNR, mainly as a result of Medicare Advantage membership growth. In addition, 2019 was impacted by an increase in the amounts owed to providers under capitated and risk sharing arrangements.

The detail of total net receivables was as follows at December 31,2019, 2018 and 2017:

				Change	
	2019	2018	2017	2019	2018
			(in millions)		
Medicare	$ 835	$ 836	$ 511	$ (1)	$ 325
Commercial and other	162	135	273	27	(138)
Military services	128	123	166	5	(43)
Allowance for doubtful accounts	(69)	(79)	(96)	10	17
Total net receivables	$ 1,056	$ 1,015	$ 854	41	161
Reconciliation to cash flow statement:					
Change in receivables from acquisition				(12)	—
Change in receivables disposed from sale of business				3	3
Change in receivables per cash flow statement resulting in cash used by operations				$ 32	$ 164

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

The decrease in commercial and other receivables in 2018 as compared to 2017, was due primarily to a decrease in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law. This decrease corresponds with our exit from the Individual Commercial business.

Military services receivables at December 31, 2019, 2018, and 2017 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our TRICARE contracts. The 2017 balance also includes transition-in receivables under our T2017 East Region contract collected in 2018.

Many provisions of the Health Care Reform Law became effective in 2014, including the non-deductible health insurance industry fee. The annual health insurance industry fee was suspended for the calendar year 2017, but resumed in calendar year 2018.The annual health insurance industry fee was again suspended in 2019, but will resume for calendar year 2020, not be deductible for income tax purposes, and significantly increase our effective tax rate. Under current law, the health industry fee will be permanently repealed beginning in calendar year 2021. We paid the federal government annual health insurance industry fees of $1.04 billion in 2018.

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

Cash Flow from Investing Activities

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $736 million in 2019, $612 million in 2018, and $524 million in 2017.

In 2018, we completed the sale of our wholly-owned subsidiary KMG to CGIC. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. Total cash and cash equivalents, including parent company funding, disposed at the time of sale, was $805 million. See Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data

During 2018 we paid cash consideration of approximately $1.1 billion to acquire a 40% minority interest in Kindred at Home, $169 million to acquire the remaining interest in MCCI, and $185 million to acquire all of FPG, as discussed in Notes 3 and 4 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $542 million,$221 million, and $2.4 billion, during 2019, 2018 and 2017 respectively.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Claims payments were $560 million higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk during 2019 and $653 million higher during 2018. Receipts from CMS associated with Medicare Part D claims subsidies for which we do not assume risk were $1.9 billion higher than claims payments during 2017. Our net payable for CMS subsidies and brand name prescription drug discounts was $229 million at December 31,2019 compared to a net payable of$331 million at December 31,2018.

Under our administrative services only TRICARE contract,health care cost payments for which we do not assume risk exceeded reimbursements from the federal government by $63 million in 2019 and reimbursements from the federal

government exceeded health care cost payments for which we do not assume riskby $38 million in 2018 and $11 million in 2017.

Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were $25 million in 2018. Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were higher than reimbursements from HHS by $44 million in 2017.

We repurchased common shares for $1.07 billion, $1.09 billion and $3.37 billion in2019, 2018 and 2017 under share repurchase plans authorized by the Board of Directors and in connection with employee stock plans.

As discussed further below, we paid dividends to stockholders of $291 million in2019, $265 million in 2018, and $220 million in 2017.

We entered into a commercial paper program in October 2014. Net repayments of commercial paper were $360 million in2019 and the maximum principal amount outstanding at any one time during 2019 was $801 million. Net proceeds from the issuance of commercial paper were $485 million in2018 and the maximum principal amount outstanding at any one time during 2018 was $923 million. Net repayments of commercial paper were $153 million in2017 and the maximum principal amount outstanding at any one time during 2017 was $500 million.

In November 2018, we entered into a $1.0 billion term note agreement with a bank at a variable rate of interest due within one year. For a detailed discussion of our debt please refer to Note 13 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

In August 2019, we issued $500 million of 3.125% senior notes due August 15, 2029 and $500 million of 3.950% senior notes due August 15, 2049. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid were $987 million. We used the net proceeds from this offering, together with available cash, to repay the $650 million outstanding amount due under our term note in August 2019, and the $400 million aggregate principal amount of our 2.625% senior notes due on maturity at October 1, 2019. In December 2017, we issued $400 million of 2.50% senior notes due December 15, 2020 and $400 million of 2.90% senior notes due December 15, 2022. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of December 31, 2017, were $794 million. We used the net proceeds, together with available cash, to fund the redemption of our$300 million aggregate principal amount of 6.30% senior notes maturing in August 2018 and our $500 million aggregate principal amount of 7.20% senior notes maturing in June 2018 at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $829 million.

The remainder of the cash used in or provided by financing activities in2019, 2018, and 2017 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

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

Stock Repurchases

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

Debt

In February 2020, we entered into a new$1 billion term loan commitment with a bank that allows for up tothree draws with the initial draw at a minimum of $300 million that matures 1 year after the first draw, subject to a 1 year extension. Following any initial draw, any unused commitments in excess of$300 million expire on June 30, 2020,

with the remaining commitments of up to $300 million available until September 30, 2020. If the initial draw has not been made by June 30, 2020, then all commitments expire on June 30, 2020. The facility fee, interest rate and financial covenants are consistent with those of our revolving credit agreement. There is no prepayment penalty.

For a detailed discussion of our debt, including our senior notes, credit agreement and commercial paper program, please refer to Note 13 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Acquisitions and Divestiture

For a detailed discussion of our acquisitions and divestitures, please refer to Notes 3 and 4 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data

Liquidity Requirements

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

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2019 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $250 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $1 million, up to a maximum 100 basis points, or annual interest expense by $3 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company increased to $1.4 billion at December 31, 2019 from $578 million at December 31, 2018. This increase primarily reflects insurance subsidiaries dividends, non-insurance subsidiaries' profits and net proceeds from debt issuance, partially offset by common stock repurchases, insurance subsidiaries' capital contributions, repayment of debt and capital expenditures. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated insurance subsidiaries paid dividends to the parent of $1.8 billion in 2019, $2.3 billion in 2018, and $1.4 billion in 2017. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. The amount of ordinary dividends that may be paid to our parent company in2020 is approximately $1 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to the parent, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31,2019 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
			(in millions)		
Debt	$ 5,700	$ 700	$ 1,000	$ 600	$ 3,400
Interest (1)	3,348	226	418	349	2,355
Operating leases (2)	501	133	215	83	70
Purchase obligations (3)	2,503	922	1,136	346	99
Future policy benefits payable and other long-term liabilities (4)	478	26	226	65	161
Total	$ 12,530	$ 2,007	$ 2,995	$ 1,443	$ 6,085

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

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046 . We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. See also Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

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

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

Off-Balance Sheet Arrangements

As of December 31, 2019, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Critical Accounting Policies and Estimates

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

Benefits Expense Recognition

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

	December 31, 2019	Percentage of Total	December 31, 2018	Percentage of Total
	(dollars in millions)			
IBNR	$ 4,150	69.1%	$ 3,361	69.1%
Reported claims in process	628	10.5%	617	12.7%
Other benefits payable	1,226	20.4%	884	18.2%
Total benefits payable	$ 6,004	100.0%	$ 4,862	100.0%

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

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderately adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2019 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
0.70%	$(308)	(3.00)%	$(270)
0.60%	$(264)	(2.75)%	$(248)
0.50%	$(220)	(2.50)%	$(225)
0.40%	$(176)	(2.25)%	$(203)
0.30%	$(132)	(2.00)%	$(180)
0.20%	$(88)	(1.75)%	$(158)
0.10%	$(44)	(1.50)%	$(135)

(a) Reflects estimated potential changes in benefits payable at December 31,2019 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31,2019 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

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

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail and Group and Specialty segment tables including information about incurred and paid claims development as of December 31, 2019, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2019	2018	2017
		(in millions)	
Balances at January 1	$ 4,862	$ 4,668	$ 4,563
Less: Reinsurance recoverables	(95)	(70)	(76)
Balances at January 1, net	4,767	4,598	4,487
Incurred related to:			
Current year	54,193	46,385	44,001
Prior years	(336)	(503)	(483)
Total incurred	53,857	45,882	43,518
Paid related to:			
Current year	(48,421)	(41,736)	(39,496)
Prior years	(4,267)	(3,977)	(3,911)
Total paid	(52,688)	(45,713)	(43,407)
Reinsurance recoverable	68	95	70
Balances at December 31	$ 6,004	$ 4,862	$ 4,668

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

	Favorable Development by Changes in Key Assumptions					
	2019		2018		2017	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (233)	(3.1)%	$ (229)	(3.3)%	$ (279)	(2.7)%
Completion factors	(103)	(0.3)%	(274)	(0.8)%	(204)	(0.7)%
Total	$ (336)		$ (503)		$ (483)	

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $336 million in 2019, $503 million in 2018, and $483 million in 2017. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2019, 2018, and 2017.

	(Favorable) Unfavorable Medical Claims Reserve Development			Change	
	2019	2018	2017	2019	2018
	(in millions)				
Retail Segment	$ (386)	$ (398)	$ (386)	$ 12	$ (12)
Group and Specialty Segment	50	(46)	(40)	96	(6)
Individual Commercial Segment	—	(57)	(56)	57	(1)
Other Businesses	—	(2)	(1)	2	(1)
Total	$ (336)	$ (503)	$ (483)	$ 167	$ (20)

The favorable medical claims reserve development for 2019, 2018, and 2017 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2019 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

There was no benefit expense excluded from the previous table for the years ended December 31, 2019 and 2018. Benefits expense reduced by $22 million associated with future policy benefits for the year ended December 31, 2017 was excluded from the previous table.

Revenue Recognition

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

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and recognized ratably during the year with adjustments each period to reflect changes in the ultimate premium.

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

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score was calculated from claims data submitted through EDS. CMS will increase that percentage to 50% in 2020 and has proposed to increase that percentage to 75% in 2021. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare," and in Item 1A. - Risk Factors.

Investment Securities

Investment securities totaled $11.4 billion, or 39% of total assets at December 31, 2019, and $10.4 billion, or 41% of total assets at December 31, 2018. The investment portfolio was primarily comprised of debt securities, detailed below, at December 31, 2019 and entirely at December 31, 2018. The fair value of debt securities were as follows at December 31, 2019 and 2018:

	12/31/2019	Percentage of Total	12/31/2018	Percentage of Total
		(dollars in millions)		
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 354	3.1%	$ 417	4.0%
Mortgage-backed securities	3,710	32.6%	2,544	24.4%
Tax-exempt municipal securities	1,463	12.9%	2,771	26.5%
Mortgage-backed securities:				
Residential	—	—%	55	0.5%
Commercial	804	7.1%	523	5.0%
Asset-backed securities	1,093	9.6%	985	9.4%
Corporate debt securities	3,947	34.7%	3,142	30.2%
Total debt securities	$ 11,371	100.0%	$ 10,437	100.0%

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2019. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 1% of our total debt securities. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2019:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2019						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 48	$ —	$ 23	$ —	$ 71	$ —
Mortgage-backed securities	315	(1)	204	(2)	519	(3)
Tax-exempt municipal securities	58	—	75	—	133	—
Mortgage-backed securities:						
Residential	—	—	—	—	—	—
Commercial	118	—	36	—	154	—
Asset-backed securities	20	—	607	(3)	627	(3)
Corporate debt securities	589	(2)	155	—	744	(2)
Total debt securities	$ 1,148	$ (3)	$ 1,100	$ (5)	$ 2,248	$ (8)

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

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

All issuers of securities we own that were trading at an unrealized loss at December 31, 2019 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2019, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2019. There were no material other-than-temporary impairments in 2019, 2018, or 2017.

Goodwill and Long-lived Assets

At December 31, 2019, goodwill and other long-lived assets represented 21% of total assets and 50% of total stockholders' equity, compared to 23% and 58%, respectively, at December 31, 2018.

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

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in Government rates, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our clinical and provider reporting units in our Healthcare Services segment. Our clinical and provider reporting units primarily provide services to our Retail members. A significant increase in the discount rate, decrease in the long-term growth rate, or substantial reductions in our underlying cash flow assumptions, including revenue growth rates, medical and operating cost trends, and projected operating income, could have a negative impact on the estimated fair value of these reporting units. The clinical reporting unit had a fair value of $544 million which exceeded its carrying value of $533 million by $11 million or 2%. If the discount rate increased 100 basis points, then the clinical reporting unit would incur an impairment loss of approximately $62 million. The provider reporting unit had a fair value of $2.3 billion which exceeded its carrying value of $1.3 billion by $1.0 billion or 78%. The provider reporting unit estimate of fair value relies on multiple assumptions regarding the underlying long-term cash flows, any one of which may be significantly impacted by future changes in estimates and may negatively impact fair value. The clinical and provider reporting units account for $524 million and $761 million, respectively, of goodwill. Impairment tests completed for 2019, 2018, and 2017 did not result in an impairment loss.

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

change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. In the past we have, and in the future we may enter into interest rate swap agreements depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $2.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2019 or December 31, 2018.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA at December 31, 2019. Our net unrealized position increased $415 million from a net unrealized loss position of $204 million at December 31, 2018 to a net unrealized gain position of $211 million at December 31, 2019. At December 31, 2019, we had gross unrealized losses of $8 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. There were no material other-than-temporary impairments during 2019. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 2.5 years as of December 31, 2019 and 2.9 years as of December 31, 2018. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $373 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2019 and 2018. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 10 year US treasury rates during the year have not exceeded 300 basis points, have changed between 200 and 300 basis points once, have changed between 100 and 200 basis points four times, and have changed by less than 100 basis points five times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2019						
Investment income (a)	$ (150)	$ (133)	$ (79)	$ 78	$ 157	$ 235
Interest expense (b)	10	9	4	(4)	(9)	(13)
Pretax	$ (140)	$ (124)	$ (75)	$ 74	$ 148	$ 222
As of December 31, 2018						
Investment income (a)	$ (154)	$ (114)	$ (57)	$ 58	$ 116	$ 175
Interest expense (b)	31	20	10	(10)	(20)	(31)
Pretax	$ (123)	$ (94)	$ (47)	$ 48	$ 96	$ 144

(a) As of December 31, 2019 and 2018, some of our investments had interest rates below 2% so the assumed hypothetical change in pretax earnings does not reflect the full 2% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2019 or December 31, 2018. There was $300 million and $645 million outstanding under our commercial paper program at December 31, 2019 and 2018, respectively. As of December 31, 2019, our interest rate under our commercial paper program was less than 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2019	**2018**
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 4,054	$ 2,343
Investment securities	10,972	10,026
Receivables, less allowance for doubtful accounts of $69 in 2019 and $79 in 2018	1,056	1,015
Other current assets	3,806	3,564
Total current assets	19,888	16,948
Property and equipment, net	1,955	1,735
Long-term investment securities	406	411
Goodwill	3,928	3,897
Equity method investment in Kindred at Home	1,063	1,047
Other long-term assets	1,834	1,375
Total assets	$ 29,074	$ 25,413
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 6,004	$ 4,862
Trade accounts payable and accrued expenses	3,754	3,067
Book overdraft	225	171
Unearned revenues	247	283
Short-term debt	699	1,694
Total current liabilities	10,929	10,077
Long-term debt	4,967	4,375
Future policy benefits payable	206	219
Other long-term liabilities	935	581
Total liabilities	17,037	15,252
Commitments and contingencies (Note 17)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,629,992 shares issued at December 31, 2019 and 198,594,841 shares issued at December 31, 2018	33	33
Capital in excess of par value	2,820	2,535
Retained earnings	17,483	15,072
Accumulated other comprehensive income (loss)	156	(159)
Treasury stock, at cost, 66,524,771 shares at December 31, 2019 and 63,028,169 shares at December 31, 2018	(8,455)	(7,320)
Total stockholders' equity	12,037	10,161
Total liabilities and stockholders' equity	$ 29,074	$ 25,413

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

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2019	**2018**	**2017**
	(in millions, except per share results)		
Revenues:			
Premiums	$ 62,948	$ 54,941	$ 52,380
Services	1,439	1,457	982
Investment income	501	514	405
Total revenues	64,888	56,912	53,767
Operating expenses:			
Benefits	53,857	45,882	43,496
Operating costs	7,381	7,525	6,567
Merger termination fee and related costs, net	—	—	(936)
Depreciation and amortization	458	405	378
Total operating expenses	61,696	53,812	49,505
Income from operations	3,192	3,100	4,262
Loss on sale of business	—	786	—
Interest expense	242	218	242
Other (income) expense, net	(506)	33	—
Income before income taxes and equity in net earnings	3,456	2,063	4,020
Provision for income taxes	763	391	1,572
Equity in net earnings of Kindred at Home	14	11	—
Net income	$ 2,707	$ 1,683	$ 2,448
Basic earnings per common share	$ 20.20	$ 12.24	$ 16.94
Diluted earnings per common share	$ 20.10	$ 12.16	$ 16.81

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

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2019	**2018**	**2017**
	(in millions)		
Net income	$ 2,707	$ 1,683	$ 2,448
Other comprehensive income (loss):			
Change in gross unrealized investment losses/gains	450	(189)	149
Effect of income taxes	(105)	51	(55)
Total change in unrealized investment gains/losses, net of tax	345	(138)	94
Reclassification adjustment for net realized gains included in investment income	(34)	(53)	(14)
Effect of income taxes	8	17	5
Total reclassification adjustment, net of tax	(26)	(36)	(9)
Other comprehensive income (loss), net of tax	319	(174)	85
Comprehensive income attributable to our equity method investment in Kindred at Home	(4)	(4)	—
Comprehensive income	$ 3,022	$ 1,505	$ 2,533

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

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2017	198,495	$ 33	$ 2,562	$ 11,454	$ (66)	$ (3,298)	$ 10,685
Net income				2,448			2,448
Other comprehensive income					85		85
Common stock repurchases			(200)			(3,165)	(3,365)
Dividends and dividend equivalents			—	(232)			(232)
Stock-based compensation			157				157
Restricted stock unit vesting	—	—	(138)			138	—
Stock option exercises	77	—	64			—	64
Balances, December 31, 2017	198,572	33	2,445	13,670	19	(6,325)	9,842
Net income				1,683			1,683
Other comprehensive loss				(4)	(178)		(182)
Common stock repurchases			50			(1,140)	(1,090)
Dividends and dividend equivalents			—	(277)			(277)
Stock-based compensation			137				137
Restricted stock unit vesting	—	—	(145)			145	—
Stock option exercises	23	—	48			—	48
Balances, December 31, 2018	198,595	33	2,535	15,072	(159)	(7,320)	10,161
Net income				2,707			2,707
Other comprehensive income					315		315
Common stock repurchases			150			(1,220)	(1,070)
Dividends and dividend equivalents			—	(296)			(296)
Stock-based compensation			163				163
Restricted stock unit vesting	32	—	(48)			48	—
Stock option exercises	3	—	20			37	57
Balances, December 31, 2019	198,630	$ 33	$ 2,820	$ 17,483	$ 156	$ (8,455)	$ 12,037

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

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW

	For the year ended December 31,		
	2019	**2018**	**2017**
		(in millions)	
Cash flows from operating activities			
Net income	$ 2,707	$ 1,683	$ 2,448
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss on sale of business	—	786	—
Net realized capital gains	(62)	(90)	(14)
Equity in net earnings of Kindred at Home	(14)	(11)	—
Stock compensation	163	137	157
Depreciation	505	444	410
Amortization	70	90	75
Provision for deferred income taxes	162	194	132
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(32)	(164)	426
Other assets	118	(484)	(582)
Benefits payable	1,142	252	105
Other liabilities	471	(676)	641
Unearned revenues	(36)	(95)	98
Other	90	107	155
Net cash provided by operating activities	5,284	2,173	4,051
Cash flows from investing activities			
Acquisitions, net of cash acquired	—	(354)	(31)
Purchase of equity method investment in Kindred at Home	—	(1,095)	—
Cash transferred in sale of business	—	(805)	—
Purchases of property and equipment	(736)	(612)	(524)
Purchases of investment securities	(6,361)	(4,687)	(6,265)
Maturities of investment securities	1,733	972	1,111
Proceeds from sales of investment securities	4,086	3,494	2,768
Net cash used in investing activities	(1,278)	(3,087)	(2,941)
Cash flows from financing activities			
(Receipts) withdrawals from contract deposits, net	(623)	(640)	1,823
Proceeds from issuance of senior notes, net	987	—	1,779
(Repayments) proceeds from issuance of commercial paper, net	(360)	485	(153)
Proceeds from term loan	—	1,000	—
Repayment of term loan	(650)	(350)	—
Repayment of long-term debt	(400)	—	(800)
Common stock repurchases	(1,070)	(1,090)	(3,365)
Dividends paid	(291)	(265)	(220)
Change in book overdraft	54	30	(71)
Proceeds from stock option exercises & other	58	45	62
Net cash used in financing activities	(2,295)	(785)	(945)
Increase (decrease) in cash and cash equivalents	1,711	(1,699)	165
Cash and cash equivalents at beginning of period	2,343	4,042	3,877
Cash and cash equivalents at end of period	$ 4,054	$ 2,343	$ 4,042

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW—(Continued)

	For the year ended December 31,		
	2019	**2018**	**2017**
Supplemental cash flow disclosures:		**(in millions)**	
Interest payments	$ 212	$ 195	$ 216
Income tax payments, net	$ 518	$ 631	$ 1,498
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 28	$ 392	$ 31
Less: Fair value of liabilities assumed	(28)	(38)	—
Cash paid for acquired businesses, net of cash acquired	$ —	$ 354	$ 31

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

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 82% of our total premiums and services revenue from contracts with the federal government in2019, including 15% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

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

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

Workforce Optimization

We initiated involuntary workforce reduction programs during 2019 and 2017, as well as a voluntary early retirement program during 2017. These programs impacted approximately 1,000 associates in 2019 and 3,600 associates in 2017. As a result, we recorded charges of $47 million in 2019 and $148 million in 2017. Payments under these programs are made upon termination during the early retirement or severance pay period.The 2017 workforce optimization obligation was $12 million at December 31, 2018 and was fully settled as ofDecember 31, 2019. The remaining 2019 workforce optimization obligation was $45 million as of December 31, 2019.

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

Aetna Merger

On February 16, 2017, under the terms of the Agreement and Plan of Merger, or Merger Agreement, with Aetna Inc., and certain wholly owned subsidiaries of Aetna Inc., which we collectively refer to as Aetna, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned "Merger termination fee and related costs, net."

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges. Operating results for our individual commercial medical business compliant with the Health Care Reform Law were challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. As a result of these and other factors, we exited our individual commercial medical business effective January 1, 2018.

The annual premium-based fee on health insurers is not deductible for tax purposes. We estimate a liability for the health insurance industry fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurance industry fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurance industry fee in September or October of each year. The Consolidated Appropriations Act enacted on December 18, 2015, included a one year suspension in 2017 of the health insurance industry fee. In 2018, we paid the federal government $1.04 billion for the annual health insurance industry fee attributed to calendar year 2018. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurance industry fee, but the fee will resume for calendar year 2020. The Further Consolidated Appropriations Act, 2020, enacted on December 20, 2019, permanently repealed the health insurance industry fee beginning in calendar year 2021.

Cash and Cash Equivalents

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

Investment Securities

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

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

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

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

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

Receivables and Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and certain contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Premiums Revenue

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium. Receivables or payables are classified as current or long-term in our consolidated balance sheet based on the timing of the expected settlement.

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

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

Medicare Part D

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

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

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2019, subsidy and discount payments of $11.8 billion exceeded reimbursements of $11.2 billion by $0.6 billion. For 2018, subsidy and discount payments of $10.3 billion exceeded reimbursements of $9.6 billion by $0.7 billion. For 2017, subsidy and discount reimbursements of $12.1 billion exceeded payments of $10.2 billion by $1.9 billion. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 7 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

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

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

Administrative services fees

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

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

Our TRICARE members are served by both in-network and out-of-network providers in accordance with our contracts. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2019, health care cost payments of approximately $6.5 billion exceeded reimbursements of approximately $6.4 billion by $63 million. For 2018, health care cost reimbursements and payments were each approximately $5.6 billion, with reimbursements exceeding payments by $38 million for the year. For 2017, health care cost reimbursements and payments were each approximately $3.4 billion with reimbursements exceeding payments by $11 million for the year.

Receivables

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

At December 31, 2019 and 2018, accounts receivable related to services were $141 million and $123 million, respectively. For the year ended December 31, 2019, we had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the consolidated balance sheet at December 31, 2019.

For the year ended December 31, 2019, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price), was not material. Further, revenue expected to be recognized in any future year related to remaining performance obligations was not material.

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 7, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates receivable was $1.3 billion at December 31, 2019 and 2018.

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

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be canceled upon30 days notice by the employer group.

Life insurance, annuities, certain health and other supplemental, and, prior to the sale of our wholly-owned subsidiary, KMG America Corporation, or KMG, in 2018, long term care policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income.

Long-Lived Assets

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

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

Equity Method Investments

We use the equity method of accounting for equity investments in companies where we are able to exercise significant influence, but not control, over operating and financial policies of the investee. Judgment regarding the level of influence over each equity method investment includes considering key factors such as our ownership interest, representation on the board of directors, organizational structure, participation in policy-making decisions and material intra-entity transactions.

Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by our share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies. Our proportionate share of the net income or loss of these companies is included in consolidated net income. Investment amounts in excess of our share of an investee's net assets are amortized over the life of the related asset creating the excess. Excess goodwill is not amortized.

We evaluate equity method investments for impairment whenever events or changes in circumstances indicate that the carrying amount of the investment might not be recoverable. Factors considered by us when reviewing an equity method investment for impairment include the length of time (duration) and the extent (severity) to which the fair value of the equity method investment has been less than carrying value, the investee’s financial condition and near-term prospects and the intent and ability to hold the investment for a period of time sufficient to allow for anticipated recovery. An impairment that is other-than-temporary is recognized in the period identified.

See Note 4 for further information.

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

Goodwill and Definite-Lived Intangible Assets

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

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our clinical and provider reporting units in our Healthcare Services segment. Our clinical and provider reporting units primarily provide services to our Retail members. A significant increase in the discount rate, decrease in the long-term growth rate, or substantial reductions in our underlying cash flow assumptions, including revenue growth rates, medical and operating cost trends, and projected operating income, could have a negative impact on the estimated fair value of these reporting units. The clinical reporting unit had a fair value of $544 million which exceeded its carrying value of $533 million by $11 million or 2%. If the discount rate increased 100 basis points, then the clinical reporting unit would incur an impairment loss of approximately $62 million. The provider reporting unit had a fair value of $2.3 billion which exceeded its carrying value of $1.3 billion by $1.0 billion or 78%. The provider reporting unit estimate of fair value relies on multiple assumptions regarding the underlying long-term cash flows, any one of which may be significantly impacted by future changes in estimates and may negatively impact fair value. The clinical and provider reporting units account for $524 million and $761 million, respectively, of goodwill. Impairment tests completed for 2019, 2018, and 2017 did not result in an impairment loss.

Definite-lived intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Definite-lived intangible assets are amortized over the useful life generally using the straight-line method. We review definite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

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

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

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

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

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

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

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

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

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise.

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

Future policy benefits payable

Future policy benefits payable includeliabilities for long-duration insurance policies including life insurance, annuities, certain health and other supplemental, and prior to the sale of KMG in 2018, long-term care policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on industry actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs.

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

Book Overdraft

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

Income Taxes

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

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

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

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model.

Additional detail regarding our stock-based compensation plans is included in Note 14.

Earnings Per Common Share

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

Additional detail regarding earnings per common share is included in Note 15.

Fair Value

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

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. We obtain at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing

service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates, and prepayment speeds. We are responsible for the determination of fair value and as such we perform analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by our third party investment adviser. In addition, on a quarterly basis we examine the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations.

Fair value of privately held debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows.

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In February 2016, the FASB issued new guidance related to accounting for leases which requires lessees to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). We adopted the new standard effective January 1, 2019, as allowed, using the modified retrospective approach. We elected the practical expedients of not reassessing whether any expired or existing contracts are or contain leases, not reassessing the lease classification for any expired or existing leases and not reassessing any initial direct costs for existing leases. In addition, we elected the practical expedient to not separate lease and nonlease components for all of our asset classes. We made a permitted accounting policy election to not apply the new guidance to leases with an initial term of 12 months or less. We recognize those lease payments in the condensed consolidated statement of income on a straight-line basis over the lease term. As of January 1, 2019, the adoption of the standard resulted in recognition of lease liabilities of approximately $470 million and right-of-use, or ROU, assets of $436 million, which equals the lease liabilities net of accrued rent and lease incentives. The standard does not materially affect our results of operations, cash flows and liquidity. See Note 10 for further information.

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

In February 2018, the FASB issued guidance which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the December 22, 2017 enactment of the Tax Cuts and Jobs Act. The new guidance is effective for us beginning January 1, 2019, with early adoption permitted. We early adopted this guidance in the first quarter of 2018 and it did not have a material impact on our results of operations, financial condition or cash flows.

Accounting Pronouncements Effective in Future Periods

In June 2016, the FASB issued guidance introducing a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The guidance is effective for us beginning January 1, 2020. The new current expected credit losses (CECL) model generally calls for the immediate recognition of all expected credit losses and applies to loans, accounts and trade receivables as well as other financial assets measured at amortized cost, loan commitments and off-balance sheet credit exposures, debt securities and other financial assets

measured at fair value through other comprehensive income, and beneficial interests in securitized financial assets. The new guidance replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available for sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities, and provides for additional disclosure requirements. Our investment portfolio consists primarily of available for sale debt securities. We adopted the new standard effective January 1, 2020. Due to the high concentration of our financial assets measured at amortized cost being with the federal government resulting in zero nonpayment risk as well as our available for sale debt securities primarily being in an unrealized gain position, the adoption of the new standard did not have a material impact on our results of operations, financial condition, or cash flows.

In September 2018, the FASB issued new guidance related to accounting for long-duration contracts of insurers which revises key elements of the measurement models and disclosure requirements for long-duration contracts issued by insurers and reinsurers. The new guidance is effective for us beginning with annual and interim periods in 2022, with earlier adoption permitted, and requires retrospective application to previously issued annual and interim financial statements. We are currently evaluating the impact on our results of operations, financial position and cash flows.

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

3. ACQUISITIONS AND DIVESTITURES

Recent Transactions

In the first quarter of 2020, we acquired privately held Enclara Healthcare, or Enclara, one of the nation's largest hospice pharmacy and benefit management providers for cash consideration of approximately $707 million, net of cash received. The purchase accounting is incomplete due to the timing of the availability of information.

Also in the first quarter of 2020, our Partners in Primary Care wholly-owned subsidiary entered into a strategic partnership with Welsh, Carson, Anderson & Stowe, or WCAS, to accelerate the expansion of our primary care model. The WCAS partnership is expected to open approximately 50 payor-agnostic, senior-focused primary care centers over 3 years beginning in 2020. Partners in Primary Care committed to the acquisition of a non-controlling interest in the approximately $600 million entity. In addition, the agreement includes a series of put and call options through which WCAS may require us to purchase their interest in the entity and, through which we may acquire WCAS's interest over the next 5 - 10 years.

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

On August 9, 2018, we completed the sale of KMG to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, included our closed block of non-strategic commercial long-term care policies. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. In connection with the sale of KMG, we recognized a pretax loss, including transaction costs, of $786 million and a corresponding $452 million tax benefit.

Prior to the sale of KMG, we entered into reinsurance contracts to transfer the risk associated with certain voluntary benefit and financial protection products previously issued primarily by KIC to a third party. We transferred approximately $245 million of cash to the third party and recorded a commensurate reinsurance recoverable as a result of these transactions. The reinsurance recoverable was included as part of the net assets disposed. There was no material impact to operating results from these reinsurance transactions.

KMG revenues and net income for the 2018 period prior to the date of sale was $182 million and $47 million, respectively. KMG revenues and net loss were $261 million and $117 million, respectively, for the year ended December 31, 2017.

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

The assets and liabilities of KMG that were disposed of onAugust 9, 2018 were as follows:

	August 9, 2018
Assets	**(in millions)**
Cash and cash equivalents	$ 805
Receivables, net	3
Investment securities	1,576
Other assets	1,085
Total assets disposed	$ 3,469
Liabilities	
Benefits payable	$ 58
Trade accounts payable and accrued expenses	70
Future policy benefits payable	2,573
Total liabilities disposed	$ 2,701

Other Acquisitions and Divestitures

In the first quarter of 2018, we acquired the remaining equity interest in MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. The purchase price consisted primarily of $169 million cash, as well as our existing investment in MCCI and a note receivable and a revolving note with an aggregate balance of $383 million. This resulted in a purchase price allocation to goodwill of$483 million, other intangible assets of $80 million, and net tangible assets of $24 million. The goodwill was assigned to the Retail and Healthcare Services segments. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 8 years. Goodwill and other intangible assets are amortizable as deductible expense for tax purposes.

In the second quarter of 2018, we acquired Family Physicians Group, or FPG, for cash consideration of approximately $185 million, net of cash received. FPG serves Medicare Advantage and Managed Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties. This resulted in a purchase price allocation to goodwill of $133 million, other intangible assets of $38 million and net tangible assets of $14 million. The goodwill was assigned to the Retail and Healthcare Services segments. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 4.9 years. The purchase price allocations for MCCI and FPG are final.

During 2019 and 2018, we acquired other health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our consolidated statements of income and consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2019, 2018 and 2017 were not material to our results of operations. Goodwill and other intangible assets acquired are partially amortizable as deductible expenses for tax purposes. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

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

4. EQUITY METHOD INVESTMENT

In the third quarter of 2018, we, along with TPG Capital, or TPG, and Welsh, Carson, Anderson & Stowe, or WCAS (together, the "Sponsors"), completed the acquisitions of Kindred Healthcare, Inc., or Kindred, and privately-held Curo Health Services, or Curo, respectively, merging Curo with the hospice business of the Kindred at Home Division, or Kindred at Home. As part of these transactions, we acquired a 40% minority interest in Kindred at Home, a leading home health and hospice company, for total cash consideration of approximately $1.1 billion.

We account for our 40% investment in Kindred at Home using the equity method of accounting. This investment is reflected as "Equity method investment in Kindred at Home" in our consolidated balance sheets, with our share of income or loss reported as "Equity in net earnings of Kindred at Home" in our consolidated statements of income.

We entered into a shareholders agreement with the Sponsors that provides for certain rights and obligations of each party. The shareholders agreement with the Sponsors includes a put option under which they have the right to require us to purchase their interest in the joint venture starting at the end of year three and ending at the end of year four following the closing. Likewise, we have a call option under which we have the right to require the Sponsors to sell their interest in the joint venture to Humana beginning at the end of 2022 and ending at the end of 2023 following the closing. The put and call options, which are exercisable at a fixed EBITDA multiple and provide a minimum return on the Sponsor's investment if exercised, are measured at fair value each period using a Monte Carlo simulation. The simulation relies on assumptions around Kindred at Home's equity value, risk free interest rates, volatility, and the details specific to the put and call options. The final purchase price allocation resulted in approximately $1 billion being allocated to the investment and $236 million and $291 million allocated to the put and call options, respectively. The fair values of the put option and call option were $28 million and $557 million, respectively, at December 31, 2019. The fair values of the put option and call option were $224 million and $246 million, respectively, at December 31, 2018.

The put option is included within other long-term liabilities and the call option is included within other long term assets. The change in fair value of the put and call options for the years ended December 31, 2019 and 2018 of $(506) million and $33 million, respectively, are reported as "Other (income) expense, net" in our consolidated statements of income.

The summarized balance sheets at December 31, 2019 and 2018, and income statement for the year ended December 31, 2019 and period beginning July 2, 2018 through December 31, 2018 of Kindred at Home were as follows:

Balance sheets	**December 31, 2019**	**December 31, 2018**
	(in millions)	
Current assets	$ 563	$ 536
Non-current assets	4,967	4,955
Current liabilities	405	351
Non-current liabilities	2,637	2,708
Shareholders' equity	2,488	2,432

Statements of income

	For the year ended December 31, 2019	**July 2, 2018 through December 31, 2018**
	(in millions)	
Revenues	$ 3,100	$ 1,587
Expenses	2,835	1,451
Net income	54	27

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

5. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows atDecember 31, 2019 and 2018, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2019				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 353	$ 1	$ —	$ 354
Mortgage-backed securities	3,628	85	(3)	3,710
Tax-exempt municipal securities	1,433	30	—	1,463
Mortgage-backed securities:				
Commercial	786	18	—	804
Asset-backed securities	1,093	3	(3)	1,093
Corporate debt securities	3,867	82	(2)	3,947
Total debt securities	$ 11,160	$ 219	$ (8)	$ 11,371
December 31, 2018				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 419	$ 1	$ (3)	$ 417
Mortgage-backed securities	2,595	3	(54)	2,544
Tax-exempt municipal securities	2,805	3	(37)	2,771
Mortgage-backed securities:				
Residential	55	—	—	55
Commercial	537	—	(14)	523
Asset-backed securities	991	1	(7)	985
Corporate debt securities	3,239	1	(98)	3,142
Total debt securities	$ 10,641	$ 9	$ (213)	$ 10,437

We also held $7 million of equity securities carried at fair value as ofDecember 31, 2019 consisting of common stock.

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

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2019 and 2018, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2019						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 48	$ —	$ 23	$ —	$ 71	$ —
Mortgage-backed securities	315	(1)	204	(2)	519	(3)
Tax-exempt municipal securities	58	—	75	—	133	—
Mortgage-backed securities:						
Commercial	118	—	36	—	154	—
Asset-backed securities	20	—	607	(3)	627	(3)
Corporate debt securities	589	(2)	155	—	744	(2)
Total debt securities	$ 1,148	$ (3)	$ 1,100	$ (5)	$ 2,248	$ (8)
December 31, 2018						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 179	$ (1)	$ 153	$ (2)	$ 332	$ (3)
Mortgage-backed securities	956	(16)	1,019	(38)	1,975	(54)
Tax-exempt municipal securities	809	(9)	1,648	(28)	2,457	(37)
Mortgage-backed securities:						
Residential	—	—	15	—	15	—
Commercial	372	(8)	133	(6)	505	(14)
Asset-backed securities	824	(7)	40	—	864	(7)
Corporate debt securities	1,434	(35)	1,439	(63)	2,873	(98)
Total debt securities	$ 4,574	$ (76)	$ 4,447	$ (137)	$ 9,021	$ (213)

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2019. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 1% of our total debt securities. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Our unrealized loss from all securities was generated from approximately 235 positions out of a total of approximately 1,515 positions at December 31, 2019. All issuers of securities we own that were trading at an unrealized loss at December 31, 2019 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2019, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we

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

will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2019.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2019, 2018, and 2017:

	2019	2018	2017
	(in millions)		
Gross realized gains	$ 129	$ 106	$ 35
Gross realized losses	(67)	(16)	(21)
Net realized capital gains	$ 62	$ 90	$ 14

There were no material other-than-temporary impairments in 2019, 2018, or 2017.

The contractual maturities of debt securities available for sale at December 31, 2019, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 1,316	$ 1,317
Due after one year through five years	1,974	2,013
Due after five years through ten years	1,724	1,780
Due after ten years	639	654
Mortgage and asset-backed securities	5,507	5,607
Total debt securities	$ 11,160	$ 11,371

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

6. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements atDecember 31, 2019 and 2018, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2019				
Cash equivalents	$ 3,660	$ 3,660	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	354	—	354	—
Mortgage-backed securities	3,710	—	3,710	—
Tax-exempt municipal securities	1,463	—	1,463	—
Mortgage-backed securities:				
Commercial	804	—	804	—
Asset-backed securities	1,093	—	1,093	—
Corporate debt securities	3,947	—	3,947	—
Total debt securities	11,371	—	11,371	—
Common stock	7	7	—	—
Total invested assets	$ 15,038	$ 3,667	$ 11,371	$ —
December 31, 2018				
Cash equivalents	$ 2,024	$ 2,024	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	417	—	417	—
Mortgage-backed securities	2,544	—	2,544	—
Tax-exempt municipal securities	2,771	—	2,771	—
Mortgage-backed securities:				
Residential	55	—	55	—
Commercial	523	—	523	—
Asset-backed securities	985	—	985	—
Corporate debt securities	3,142	—	3,142	—
Total debt securities	10,437	—	10,437	—
Total invested assets	$ 12,461	$ 2,024	$ 10,437	$ —

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

Financial Liabilities

Our debt is recorded at carrying value in our consolidated balance sheets. The carrying value of our senior notes debt outstanding, net of unamortized debt issuance costs, was $5,366 million at December 31, 2019 and $4,774 million at December 31, 2018. The fair value of our senior note debt was $5,916 million at December 31, 2019 and $4,885 million at December 31, 2018. The fair value of our senior note debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Due to the short-term nature, carrying value approximates fair value for our term note and commercial paper borrowings. The outstanding commercial paper borrowings were $300 million at December 31, 2019 and we repaid the term note balance in August 2019. The term note outstanding and commercial paper borrowings were $1,295 million at December 31, 2018.

Put and Call Options Measured at Fair Value

The put and call options fair values, derived from the Monte Carlo simulation, were $28 million and $557 million, respectively at December 31, 2019 and $224 million and $246 million, respectively at December 31, 2018. The significant unobservable inputs utilized in these Level 3 fair value measurements (and selected values) include the enterprise value of Kindred at Home, annualized volatility (19.8%) and secured credit rate (2.2%). Enterprise value was derived from a discounted cash flow model, which utilized significant unobservable inputs for long-term net operating profit after tax margin, or NOPAT, (12.0%) to measure underlying cash flows, weighted average cost of capital (10.0%) and long term growth rate (3.0%). The calculation of NOPAT utilized net income plus after tax interest expense.

We regularly evaluate each of the assumptions used in establishing these assets and liabilities. Significant changes in assumptions for weighted average cost of capital, long term growth rates, NOPAT, volatility, credit spreads, risk free rate, and underlying cash flow estimates, could result in significantly lower or higher fair value measurements. A change in one of these assumptions is not necessarily accompanied by a change in another assumption.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we acquired MCCI, FPG, and other health and wellness related businesses during 2019, 2018, and 2017. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected future cash flows and discount rates used in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2019, 2018, or 2017.

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

7. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS.The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2019 and 2018. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2019		2018	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 5	$ 585	$ 15	$ 172
Trade accounts payable and accrued expenses	(120)	(356)	(103)	(503)
Net current (liability) asset	(115)	229	(88)	(331)
Other long-term assets	6	—	7	—
Other long-term liabilities	(61)	—	(89)	—
Net long-term liability	(55)	—	(82)	—
Total net (liability) asset	$ (170)	$ 229	$ (170)	$ (331)

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2019 and 2018.

	2019	2018
	(in millions)	
Land	$ 20	$ 20
Buildings and leasehold improvements	874	766
Equipment	922	890
Computer software	2,799	2,372
	4,615	4,048
Accumulated depreciation	(2,660)	(2,313)
Property and equipment, net	$ 1,955	$ 1,735

Depreciation expense was $505 million in 2019, $444 million in 2018, and $410 million in 2017, including amortization expense for capitalized internally developed and purchased software of $343 million in 2019, $298 million in 2018, and $287 million in 2017.

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

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31,2019 and 2018 were as follows:

	Retail	Group and Specialty	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2018	$ 1,059	$ 261	$ 1,961	$ 3,281
Acquisitions	476	—	140	616
Balance at December 31, 2018	1,535	261	2,101	3,897
Acquisitions	—	—	31	31
Balance at December 31, 2019	$ 1,535	$ 261	$ 2,132	$ 3,928

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2019 and 2018.

	Weighted Average Life	2019			2018		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Customer contracts/relationships	8.7 years	$ 646	$ 496	$ 150	$ 646	$ 434	$ 212
Trade names and technology	6.4 years	84	84	—	84	83	1
Provider contracts	11.8 years	70	44	26	68	37	31
Noncompetes and other	7.3 years	29	28	1	29	28	1
Total other intangible assets	8.7 years	$ 829	$ 652	$ 177	$ 827	$ 582	$ 245

Amortization expense for other intangible assets was approximately$70 million in 2019, $90 million in 2018, and $75 million in 2017. Amortization expense for 2018 included $12 million associated with the write-off of a trade name value reflecting the re-branding of certain provider assets.

The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2020	$ 68
2021	34
2022	31
2023	18
2024	11

10. LEASES

We determine if a contract contains a lease by evaluating the nature and substance of the agreement. We lease facilities, computer hardware, and other furniture and equipment. Leases with an initial term of 12 months or less are not recorded on the balance sheet; we recognize lease expense for these leases on a straight-line basis over the lease term. For new lease agreements, we combine lease and nonlease components for all of our asset classes. See Note 2 for further information.

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

When portions of the lease payments are not fixed or depend on an index or rate, we consider those payments to be variable in nature. Our variable lease payments include, but are not limited to, common area maintenance, taxes and insurance which are not dependent upon an index or rate. Variable lease payments are recorded in the period in which the obligation for the payment is incurred. Most leases include options to renew, with renewal terms that can extend the lease term. The exercise of lease renewal options is at our sole discretion. Certain leases also include options to purchase the leased property. The depreciable life of assets and leasehold improvements are limited by the expected lease term, unless there is a transfer of title or purchase option reasonably certain of exercise. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

At December 31, 2019, $410 million of operating ROU assets are included within other long-term assets in our consolidated balance sheet. Additionally, at December 31, 2019, $116 million and $332 million of operating lease liabilities are included within trade accounts payable and accrued expenses and other long-term liabilities, respectively, in our consolidated balance sheet based on the remaining lease term.

For the year-ended December 31, 2019, total fixed operating lease costs, excluding short-term lease costs, were $154 million and are included within operating costs in our consolidated statement of income. Short-term lease costs were not material. In addition, for the year-ended December 31, 2019, total variable operating lease costs were $82 million and are included within operating costs in our consolidated statement of income. We sublease facilities or partial facilities to third party tenants for space not used in our operations. For the year-ended December 31, 2019, sublease rental income was $45 million and is included within operating costs in our consolidated statement of income.

The weighted average remaining lease term is 4.9 years with a weighted average discount rate of 4.1% at December 31, 2019. For the year-ended December 31, 2019, cash paid for amounts included in the measurement of lease liabilities included within our operating cash flows was $151 million.

Maturity of Lease Liabilities	December 31, 2019
	(in millions)
2020	$ 133
2021	117
2022	97
2023	52
2024	31
After 2024	70
Total lease payments	500
Less: Interest	52
Present value of lease liabilities	$ 448

As most of our leases do not provide an implicit rate, we use our incremental borrowing rate, as adjusted for collateralized borrowings, based on the information available at date of adoption or commencement date in determining the present value of lease payments.

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

For the year ended 2018, under prior lease disclosure requirements

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the years ended December 31, 2018 and 2017:

	2018	2017
	(in millions)	
Rent expense	$ 167	$ 204
Sublease rental income	(32)	(33)
Net rent expense	$ 135	$ 171

Future annual minimum payments due subsequent to December 31, 2018 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31,:			
2019	$ 147	$ (13)	$ 134
2020	113	(12)	101
2021	96	(10)	86
2022	79	(9)	70
2023	34	(9)	25
Thereafter	50	(23)	27
Total	$ 519	$ (76)	$ 443

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

11. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2019, 2018 and 2017:

	2019	2018	2017
		(in millions)	
Balances at January 1	$ 4,862	$ 4,668	$ 4,563
Less: Reinsurance recoverables	(95)	(70)	(76)
Balances at January 1, net	4,767	4,598	4,487
Incurred related to:			
Current year	54,193	46,385	44,001
Prior years	(336)	(503)	(483)
Total incurred	53,857	45,882	43,518
Paid related to:			
Current year	(48,421)	(41,736)	(39,496)
Prior years	(4,267)	(3,977)	(3,911)
Total paid	(52,688)	(45,713)	(43,407)
Reinsurance recoverable	68	95	70
Balances at December 31	$ 6,004	$ 4,862	$ 4,668

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $336 million in 2019, $503 million in 2018, and $483 million in 2017. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2019, 2018, and 2017.

	(Favorable) Unfavorable Medical Claims Reserve Development		
	2019	2018	2017
Retail Segment	$ (386)	$ (398)	$ (386)
Group and Specialty Segment	50	(46)	(40)
Individual Commercial Segment	—	(57)	(56)
Other Businesses	—	(2)	(1)
Total	$ (336)	$ (503)	$ (483)

The medical claims reserve development for 2019, 2018, and 2017 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development primarily resulted from our Medicare Advantage medical business. The unfavorable Group and Specialty medical claims reserve development for 2019 reflects higher than expected claims trend and provider settlements.

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

Benefits expense reduction of $22 million associated with long-duration future policy benefits for the year ended December 31 2017 was excluded from the previous short duration benefits payable rollforward table.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our segments as of December 31, 2019, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2017 and 2018 is presented as supplementary information.

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

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2019, 2018 and 2017:

	2019	2018	2017
		(in millions)	
Balances at January 1	$ 4,338	$ 3,963	$ 3,506
Less: Reinsurance recoverables	(95)	(70)	(76)
Balances at January 1, net	4,243	3,893	3,430
Incurred related to:			
Current year	48,983	41,323	38,604
Prior years	(386)	(398)	(386)
Total incurred	48,597	40,925	38,218
Paid related to:			
Current year	(43,831)	(37,189)	(34,781)
Prior years	(3,714)	(3,386)	(2,974)
Total paid	(47,545)	(40,575)	(37,755)
Reinsurance recoverable	68	95	70
Balances at December 31	$ 5,363	$ 4,338	$ 3,963

At December 31, 2019, benefits payable for our Retail segment included IBNR of approximately $3.6 billion, primarily associated with claims incurred in 2019. The cumulative number of reported claims as of December 31, 2019 was approximately 123.0 million for claims incurred in 2019, 109.6 million for claims incurred in 2018, and 104.7 million for claims incurred in 2017.

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

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2019, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2017 Unaudited	2018 Unaudited	2019
	(in millions)		
2017	$ 38,604	$ 38,341	$ 38,310
2018		41,323	40,984
2019			48,983
Total			$ 128,277

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2017 Unaudited	2018 Unaudited	2019
	(in millions)		
2017	$ 34,781	$ 38,232	$ 38,310
2018		37,189	40,841
2019			43,831
Total			$ 122,982
All outstanding benefit liabilities before 2017, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 5,295

Group and Specialty Segment

Activity in benefits payable for our Group and Specialty segment, excluding military services, was as follows for the years ended December 31 2019, 2018 and 2017:

	2019	2018	2017
		(in millions)	
Balances at January 1	$ 517	$ 568	$ 579
Incurred related to:			
Current year	5,708	5,466	5,403
Prior years	50	(46)	(40)
Total incurred	5,758	5,420	5,363
Paid related to:			
Current year	(5,081)	(4,957)	(4,843)
Prior years	(553)	(514)	(531)
Total paid	(5,634)	(5,471)	(5,374)
Balances at December 31	$ 641	$ 517	$ 568

At December 31, 2019, benefits payable for our Group and Specialty segment included IBNR of approximately $567 million, primarily associated with claims incurred in 2019. The cumulative number of reported claims as of December 31, 2019 was approximately 9.7 million for claims incurred in 2019, 10.8 million for claims incurred in 2018, and 11.1 million for claims incurred in 2017.

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

The following tables provide information about incurred and paid claims development for the Group and Specialty segment as of December 31, 2019, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2017 Unaudited**	**2018 Unaudited**	**2019**
		(in millions)	
2017	$ 5,403	$ 5,358	$ 5,372
2018		5,466	5,501
2019			5,708
Total			$ 16,581

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2017 Unaudited**	**2018 Unaudited**	**2019**
		(in millions)	
2017	$ 4,843	$ 5,351	$ 5,372
2018		4,957	5,487
2019			5,081
Total			$ 15,940
All outstanding benefit liabilities before 2017, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 641

Reconciliation to Consolidated

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

	December 31, 2019
Net outstanding liabilities	
Retail	$ 5,295
Group and Specialty	641
Benefits payable, net of reinsurance	5,936
Reinsurance recoverable on unpaid claims	
Retail	68
Total benefits payable, gross	$ 6,004

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

12. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31,2019, 2018 and 2017:

	2019	2018	2017
		(in millions)	
Current provision:			
Federal	$ 560	$ 139	$ 1,324
States and Puerto Rico	41	58	116
Total current provision	601	197	1,440
Deferred expense	162	194	132
Provision for income taxes	$ 763	$ 391	$ 1,572

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 312019, 2018 and 2017 due to the following:

	2019	2018	2017
		(in millions)	
Income tax provision at federal statutory rate	$ 729	$ 436	$ 1,407
States, net of federal benefit, and Puerto Rico	49	42	80
Tax exempt investment income	(6)	(11)	(22)
Health insurance industry fee	—	243	—
Nondeductible executive compensation	25	17	36
Tax reform	—	(39)	133
KMG sale	—	(272)	—
Other, net	(34)	(25)	(62)
Provision for income taxes	$ 763	$ 391	$ 1,572

The tax reform law enacted on December 22, 2017 (the "Tax Reform Law") reduced the statutory federal corporate income tax rate to 21 percent from 35 percent, beginning in 2018, and required a mandatory deemed repatriation of undistributed foreign earnings. The rate reduction required a remeasurement of our net deferred tax asset. These items resulted in an estimated increase in our 2017 tax provision of approximately $133 million, including approximately $10 million for the deemed repatriation tax imposed on the undistributed earnings of our Puerto Rico operations. Revisions to our prior estimate for the income tax effects of the Tax Reform Law decreased our 2018 tax provision by approximately $39 million.

The incremental tax benefit on the sale of KMG of$272 million resulted from a tax loss higher than the loss recorded in the statement of income for the year ended December 31, 2018 due to a higher tax basis in KMG than book basis. In addition, the amount reflects our ability to carryback the capital loss to tax years 2015, 2016 and 2017 at the historical tax rate of 35 percent instead of the current tax rate of 21 percent.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled.

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

Principal components of our net deferred tax balances at December 31,2019 and 2018 were as follows:

	Assets (Liabilities)	
	2019	2018
	(in millions)	
Compensation and other accrued expense	$ 111	$ 89
Benefits payable	89	79
Net operating loss carryforward	42	38
Deferred acquisition costs	22	17
Unearned revenues	8	9
Other	8	8
Capital loss carryforward	1	15
Investment securities	—	44
Total deferred income tax assets	281	299
Valuation allowance	(45)	(54)
Total deferred income tax assets, net of valuation allowance	236	245
Depreciable property and intangible assets	(329)	(273)
Investment securities	(181)	—
Prepaid expenses	(64)	(52)
Future policy benefits payable	(3)	(5)
Total deferred income tax liabilities	(577)	(330)
Total net deferred income tax liabilities	$ (341)	$ (85)

All deferred tax liabilities and assets are classified as noncurrent in our consolidated balance sheets as other long-term liabilities at December 31, 2019 and 2018.

At December 31, 2019, we had approximately $114 million of net operating losses and $2 million of capital losses to carry forward. These loss carryforwards, if not used to offset future taxable income or capital gain, will expire from 2020 through 2033. Due to limitations and uncertainty regarding our ability to use some of the loss carryforwards and certain other deferred tax assets, a valuation allowance of $45 million was established. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover these deferred tax assets.

We file income tax returns in the United States and Puerto Rico. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2017 and prior years. Our 2018 tax return is in the post-filing review period under the Compliance Assurance Process, or CAP. Our 2019 tax return is under advance review by the IRS under CAP. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2016. We are not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

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

13. DEBT

The carrying value of debt outstanding was as follows at December 31,2019 and 2018:

	2019	2018
	(in millions)	
Short-term debt:		
Commercial paper	$ 300	$ 645
Term note	—	650
Senior notes:		
$400 million, 2.625% due October 1, 2019	—	399
$400 million, 2.50% due December 15, 2020	399	—
Total short-term debt	$ 699	$ 1,694
Long-term debt:		
Senior notes:		
$400 million, 2.50% due December 15, 2020	$ —	$ 398
$600 million, 3.15% due December 1, 2022	598	596
$400 million, 2.90% due December 15, 2022	397	396
$600 million, 3.85% due October 1, 2024	597	597
$600 million, 3.95% due March 15, 2027	595	594
$500 million, 3.125% due August 15, 2029	495	—
$250 million, 8.15% due June 15, 2038	262	263
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	739	739
$400 million, 4.80% due March 15, 2047	396	396
$500 million, 3.95% due August 15, 2049	492	—
Total long-term debt	$ 4,967	$ 4,375

Maturities of the short-term and long-term debt for the years ending December 31, are as follows:

For the years ending December 31,	(in millions)
2020	$ 700
2021	—
2022	1,000
2023	—
2024	600
Thereafter	3,400

Senior Notes

In August 2019, we issued $500 million of 3.125% senior notes due August 15, 2029 and $500 million of 3.950% senior notes due August 15, 2049. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid were $987 million. We used the net proceeds from this offering, together with available cash, to repay the $650 million outstanding amount due under our term note in August 2019, and the $400 million aggregate principal amount of our 2.625% senior notes due on its maturity date of October 1, 2019.

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

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes contain a change of control provision that may require us to purchase the notes under certain circumstances. We recognized a loss on extinguishment of debt of approximately $17 million in 2017 for the early redemption of senior notes, which is included in interest expense in the consolidated statements of income.

Credit Agreement

Our 5-year, $2.0 billion unsecured revolving credit agreement expires May 2022. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. If drawn upon, the revolving credit would revert to using the alternative base rate once LIBOR is discontinued. The LIBOR spread, currently 110.0 basis points, varies depending on our credit ratings ranging from 91.0 to 150.0 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15.0 basis points, may fluctuate between 9.0 and 25.0 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive covenants and a financial covenant regarding maximum debt to capitalization of 50% as well as customary events of default. We are in compliance with this financial covenant, with an actual debt to capitalization of 32% as measured in accordance with the credit agreement as of December 31, 2019. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the credit agreement to a maximum of $2.5 billion, through a $500 million incremental loan facility.

At December 31, 2019, we had no borrowings and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2019, we had $2 billion of remaining borrowing capacity (which excludes the uncommitted $500 million incremental loan facility under the credit agreement), none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

Under our commercial paper program we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time not to exceed $2 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2019 was $801 million, with $300 million outstanding at December 31, 2019 compared to $645 million outstanding at December 31, 2018. The outstanding commercial paper at December 31, 2019 had a weighted average annual interest rate of 2%.

Term Note

In November 2018, we entered into a $1.0 billion term note agreement with a bank at a variable rate of interest due within one year. We may elect to incur interest at either the bank's base rate or LIBOR plus 115 basis points. The base rate is defined as the higher of the daily federal funds rate plus 50 basis points; or the bank's prime rate; or LIBOR plus 100 basis points. The term note shares the customary terms and provisions as well as financial covenants of our credit agreement, as discussed above. The note was prepayable without penalty. We repaid $350 million prior to December 31, 2018 and repaid the outstanding balance of $650 million in August 2019.

In February 2020, we entered into a new $1 billion term loan commitment with a bank that allows for up to three draws with the initial draw at a minimum of $300 million that matures 1 year after the first draw, subject to a 1 year extension. Following any initial draw, any unused commitments in excess of $300 million expire on June 30, 2020, with the remaining commitments of up to $300 million available until September 30, 2020. If the initial draw

has not been made by June 30, 2020, then all commitments expire on June 30, 2020. The facility fee, interest rate and financial covenants are consistent with those of our revolving credit agreement. There is no prepayment penalty.

14. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $221 million in 2019, $197 million in 2018, and $217 million in 2017. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $366.52 on December 31, 2019, approximately 11% of the retirement and savings plan's assets were invested in our common stock, or approximately1.6 million shares, representing approximately 1.2% of the shares outstanding as of December 31, 2019. At December 31, 2019, approximately 1.8 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. Awards generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

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

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2019, 2018, and 2017:

	2019	2018	2017
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 152	$ 124	$ 145
Stock options	11	13	12
Total stock-based compensation expense	163	137	157
Tax benefit recognized	(35)	(21)	(32)
Stock-based compensation expense, net of tax	$ 128	$ 116	$ 125

Stock-based compensation expense for certain restricted stock in 2017 included a $29 million modification expense for certain awards.

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the

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

deductions taken on our tax returns from option exercises and restricted stock vesting totaled $25 million in 2019, $49 million in 2018, and $68 million in 2017. There was no capitalized stock-based compensation expense during these years.

At December 31, 2019, there were 12.5 million shares reserved for stock award plans under the Humana Inc. 2011 Stock Incentive Plan, or 2011 Plan, and 16.0 million shares reserved for stock award plans under the Humana Inc. 2019 Stock Incentive Plan, or 2019 Plan. These reserved shares included giving effect to, under the 2011 Plan, 3.8 million shares of common stock available for future grants assuming all stock options were granted or 1.7 million shares available for future grants assuming all restricted stock were granted. These reserved shares included giving effect to, under the 2019 Plan, 15.8 million shares of common stock available for future grants assuming all stock options were granted or 4.7 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock grants also include performance-based conditions generally associated with return on invested capital and strategic membership growth. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $302.09 in 2019, $276.62 in 2018, and $222.35 in 2017. Activity for our restricted stock was as follows for the year ended December 31, 2019:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2018	964	$ 213.99
Granted	503	302.09
Vested	(421)	239.42
Forfeited	(70)	269.06
Nonvested restricted stock at December 31, 2019	976	$ 245.21

Approximately 22% of the nonvested restricted stock at December 31,2019 included performance-based conditions.

The fair value of shares vested was $141 million during 2019, $298 million during 2018, and $306 million during 2017. Total compensation expense not yet recognized related to nonvested restricted stock was $164 million at December 31, 2019. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

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

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

The weighted-average fair value of each option granted during2019, 2018, and 2017 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2019	2018	2017
Weighted-average fair value at grant date	$ 68.53	$ 63.67	$ 49.81
Expected option life (years)	4.1 years	4.1 years	4.1 years
Expected volatility	25.5%	26.1%	27.1%
Risk-free interest rate at grant date	2.4%	2.5%	2.0%
Dividend yield	0.7%	0.7%	0.7%

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

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

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

Activity for our option plans was as follows for the year ended December 31,2019:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2018	677	$ 213.17
Granted	121	304.59
Exercised	(305)	189.24
Forfeited	—	—
Options outstanding at December 31, 2019	493	$ 250.46
Options exercisable at December 31, 2019	109	$ 216.49

As of December 31, 2019, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of$56 million, and a weighted-average remaining contractual term of 4.8 years. As of December 31, 2019, exercisable stock options had an aggregate intrinsic value of$16 million, and a weighted-average remaining contractual term of 3.9 years. The total intrinsic value of stock options exercised during2019 was $43 million, compared with $43 million during 2018 and $44 million during 2017. Cash received from stock option exercises totaled$58 million in 2019, $50 million in 2018, and $63 million in 2017.

Total compensation expense not yet recognized related to nonvested options was$11 million at December 31, 2019. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years.

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

15. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31,2019, 2018 and 2017:

	2019	2018	2017
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 2,707	$ 1,683	$ 2,448
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	134,055	137,486	144,493
Dilutive effect of:			
Employee stock options	107	194	172
Restricted stock	565	723	920
Shares used to compute diluted earnings per common share	134,727	138,403	145,585
Basic earnings per common share	$ 20.20	$ 12.24	$ 16.94
Diluted earnings per common share	$ 20.10	$ 12.16	$ 16.81
Number of antidilutive stock options and restricted stock awards excluded from computation	478	223	539

16. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in2017, 2018, and 2019 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2017	$1.49	$216
2018	$1.90	$262
2019	$2.15	$289

On October 24, 2019, the Board declared a cash dividend of$0.55 per share that was paid onJanuary 31, 2020 to stockholders of record on December 31, 2019, for an aggregate amount of$73 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2020, the Board declared a cash dividend of$0.625 per share payable on April 24, 2020 to stockholders of record on March 31, 2020.

Stock Repurchases

Our Board of Directors may authorize the purchase of our common shares. Under our share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing.

On February 14, 2017, our Board of Directors authorized the repurchase of up to$2.25 billion of our common shares expiring on December 31, 2017, exclusive of shares repurchased in connection with employee stock plans.

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

On February 16, 2017, we entered into an accelerated share repurchase agreement, the February 2017 ASR, with Goldman, Sachs & Co. LLC, or Goldman Sachs, to repurchase $1.5 billion of our common stock as part of the $2.25 billion share repurchase authorized on February 14, 2017. On February 22, 2017, we made a payment of $1.5 billion to Goldman Sachs from available cash on hand and received an initial delivery of 5.83 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $1.2 billion increase in treasury stock, which reflected the value of the initial 5.83 million shares received upon initial settlement, and a $300 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the February 2017 ASR. Upon settlement of the February 2017 ASR on August 28, 2017, we received an additional 0.84 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the agreement, less a discount, of $224.81, bringing the total shares received under this program to 6.67 million. In addition, upon settlement we reclassified the $300 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock. Subsequent to settlement of the February 2017 ASR, we repurchased an additional 3.04 million shares in the open market, utilizing the remaining $750 million of the $2.25 billion authorization prior to expiration.

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans.

On December 21, 2017, we entered into an accelerated stock repurchase agreement, the December 2017 ASR, with Bank of America, N.A., or BofA, to repurchase $1.0 billion of our common stock as part of the $3.0 billion share repurchase program authorized on December 14, 2017. On December 22, 2017, we made a payment of $1.0 billion to BofA from available cash on hand and received an initial delivery of 3.28 million shares of our common stock from BofA based on the then current market price of Humana common stock. The payment to BofA was recorded as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 3.28 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by BofA pending final settlement of the December 2017 ASR. Upon settlement of the ASR on March 26, 2018, we received an additional 0.46 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the ASR Agreement, less a discount, of $267.55, bringing the total shares received under this program to 3.74 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by BofA from capital in excess of par value to treasury stock.

On November 28, 2018, we entered into an accelerated stock repurchase agreement, the November 2018 ASR, with Goldman Sachs to repurchase $750 million of our common stock as part of the $3.0 billion share repurchase program authorized by the Board of Directors on December 14, 2017. On November 29, 2018, we made a payment of $750 million to Goldman Sachs from available cash on hand and received an initial delivery of 1.94 million shares of our common stock from Goldman Sachs. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $600 million increase in treasury stock, which reflected the value of the initial 1.94 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the November 2018 ASR. Upon final settlement of the November 2018 ASR on February 28, 2019, we received an additional 0.6 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $295.15, bringing the total shares received under this program to 2.54 million. In addition, upon settlement we reclassified the $150 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock.

On July 30, 2019, the Board of Directors replaced a previous share repurchase authorization of up to $3 billion (of which approximately $1.03 billion remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on June 30, 2022.

On July 31, 2019, we entered into an accelerated stock repurchase agreement, the July 2019 ASR, with Citibank, N.A., or Citi, to repurchase $1 billion of our common stock. On August 2, 2019, we made a payment of $1 billion to

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

Citi and received an initial delivery of 2.7 million shares of our common stock. We recorded the payment to Citi as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 2.7 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by Citi pending final settlement of the July 2019 ASR. Upon final settlement of the July 2019 ASR on December 26, 2019, we received an additional 0.7 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $296.19, bringing the total shares received under the July 2019 ASR to 3.4 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by Citi from capital in excess of par value to treasury stock.

Our remaining repurchase authorization was approximately $2.0 billion as of February 19, 2020.

Excluding shares acquired in connection with employee stock plans, share repurchases were as follows during the years ended December 31, 2019, 2018 and 2017.

		2019		2018		2017	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
			(in millions)				
February 2017	2,250	—	—	—	—	9.71	2,250
December 2017	3,000	—	—	3.07	1,024	3.28	800
July 2019	3,000	3.40	1,000	—	—	—	—
Total repurchases		3.40	$ 1,000	3.07	$ 1,024	12.99	$ 3,050

In connection with employee stock plans, we acquired 0.2 million common shares for $70 million in 2019, 0.4 million common shares for $116 million in 2018, and 0.5 million common shares for $115 million in 2017.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $8.0 billion and $7.6 billion as of December 31, 2019 and 2018, respectively, which exceeded aggregate minimum regulatory requirements of $5.9 billion and $5.2 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2020 is approximately $1.0 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $1.8 billion in 2019, $2.3 billion in 2018, and $1.4 billion in 2017.

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

17. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $922 million in 2020, $647 million in 2021, $489 million in 2022, $246 million in 2023, and $100 million in 2024. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2019, we were not involved in any SPE transactions.

Guarantees and Indemnifications

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

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

Government Contracts

Our Medicare products, which accounted for approximately 82% of our total premiums and services revenue for the year ended December 31,2019, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2020, and all of our product offerings filed with CMS for2020 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to

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

CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score was calculated from claims data submitted through EDS. CMS will increase that percentage to 50% in 2020 and has proposed to increase that percentage to 75% in 2021. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

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

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We believe that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and have provided substantive comments to CMS on the

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

Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial position, or cash flows.

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

We believe that CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2019, our military services business, which accounted for approximately1% of our total premiums and services revenue for theyear ended December 31, 2019, primarily consisted of the TRICARE T2017 East Region contract.The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our state-based Medicaid business accounted for approximately4% of our total premiums and services revenue for theyear ended December 31, 2019. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Florida for Long Term Support Services (LTSS), and in Illinois for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program.

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

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

Legal Proceedings and Certain Regulatory Matters

As previously disclosed, the Civil Division of the United States Department of Justice provided us with an information request in December 2014, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned*United States of America ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by us in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by us under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. We take seriously our obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations since the transfer to the Western District of Kentucky. We have engaged in active discovery with the relator who has pursued the matter on behalf of the United States following its unsealing, and expect that discovery process to conclude in the near future and for the Court to consider our motion for summary judgment.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under Health Care Reform , for years 2014, 2015 and 2016. Our case has been stayed by the Court, pending resolution of similar cases filed by other insurers. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid risk corridor payments as of December 31, 2019. We have fully recognized all liabilities due to the federal government that we have incurred under the risk corridor program, and have paid all amounts due to the federal government as required. There is no assurance that we will prevail in the lawsuit.

Other Lawsuits and Regulatory Matters

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

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business
operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate and payment disputes, including disputes over reimbursement rates required by statute, general contractual matters, intellectual property matters, and challenges to subrogation practices. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

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

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

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

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

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

18. SEGMENT INFORMATION

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. Beginning January 1, 2018, we exited the individual commercial fully-insured medical health insurance business, as well as certain other business in 2018, and therefore no longer report separately the Individual Commercial segment and the Other Businesses category in the current year. Previously, the Other Businesses category included businesses that were not individually reportable because they did not meet the quantitative thresholds required by generally accepted accounting principles, primarily our closed-block of commercial long-term care insurance policies which were sold in 2018. The reportable 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, the chief operating decision maker, to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes our military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment

includes our services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our minority investment in Kindred at Home.

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

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

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $14.9 billion in 2019, $13.4 billion in 2018, and $13.5 billion in 2017. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $117 million in 2019, $129 million in 2018, and $107 million in 2017.

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

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

	Retail	Group and Specialty	Healthcare Services	Eliminations/ Corporate	Consolidated
			(in millions)		
2019					
External revenues					
Premiums:					
Individual Medicare Advantage	$ 43,128	$ —	$ —	$ —	$ 43,128
Group Medicare Advantage	6,475	—	—	—	6,475
Medicare stand-alone PDP	3,165	—	—	—	3,165
Total Medicare	52,768	—	—	—	52,768
Fully-insured	588	5,123	—	—	5,711
Specialty	—	1,571	—	—	1,571
Medicaid and other	2,898	—	—	—	2,898
Total premiums	56,254	6,694	—	—	62,948
Services revenue:					
Provider	—	—	446	—	446
ASO and other	17	790	—	—	807
Pharmacy	—	—	186	—	186
Total services revenue	17	790	632	—	1,439
Total external revenues	56,271	7,484	632	—	64,387
Intersegment revenues					
Services	—	18	18,255	(18,273)	—
Products	—	—	6,894	(6,894)	—
Total intersegment revenues	—	18	25,149	(25,167)	—
Investment income	195	23	2	281	501
Total revenues	56,466	7,525	25,783	(24,886)	64,888
Operating expenses:					
Benefits	48,602	5,758	—	(503)	53,857
Operating costs	5,306	1,651	24,852	(24,428)	7,381
Depreciation and amortization	323	88	156	(109)	458
Total operating expenses	54,231	7,497	25,008	(25,040)	61,696
Income from operations	2,235	28	775	154	3,192
Interest expense	—	—	—	242	242
Other income, net	—	—	—	(506)	(506)
Income before income taxes and equity in net earnings	2,235	28	775	418	3,456
Equity in net earnings of Kindred at Home	—	—	14	—	14
Segment earnings	$ 2,235	$ 28	$ 789	$ 418	$ 3,470

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 82% for 2019, compared to 81% for 2018, and 79% for 2017.

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

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2018							
External revenues							
Premiums:							
Individual Medicare Advantage	$ 35,656	$ —	$ —	$ —	$ —	$ —	$ 35,656
Group Medicare Advantage	6,103	—	—	—	—	—	6,103
Medicare stand-alone PDP	3,584	—	—	—	—	—	3,584
Total Medicare	45,343	—	—	—	—	—	45,343
Fully-insured	510	5,444	—	8	—	—	5,962
Specialty	—	1,359	—	—	—	—	1,359
Medicaid and other	2,255	—	—	—	22	—	2,277
Total premiums	48,108	6,803	—	8	22	—	54,941
Services revenue:							
Provider	—	—	404	—	—	—	404
ASO and other	11	835	—	—	4	—	850
Pharmacy	—	—	203	—	—	—	203
Total services revenue	11	835	607	—	4	—	1,457
Total external revenues	48,119	7,638	607	8	26	—	56,398
Intersegment revenues							
Services	—	18	16,840	—	—	(16,858)	—
Products	—	—	6,330	—	—	(6,330)	—
Total intersegment revenues	—	18	23,170	—	—	(23,188)	—
Investment income	136	23	34	—	110	211	514
Total revenues	48,255	7,679	23,811	8	136	(22,977)	56,912
Operating expenses:							
Benefits	40,925	5,420	—	(70)	77	(470)	45,882
Operating costs	5,327	1,810	22,905	4	6	(22,527)	7,525
Depreciation and amortization	270	88	163	—	—	(116)	405
Total operating expenses	46,522	7,318	23,068	(66)	83	(23,113)	53,812
Income from operations	1,733	361	743	74	53	136	3,100
Loss on sale of business	—	—	—	—	—	786	786
Interest expense	—	—	—	—	—	218	218
Other expense, net	—	—	—	—	—	33	33
Income (loss) before income taxes and equity in net earnings	1,733	361	743	74	53	(901)	2,063
Equity in net earnings of Kindred at Home	—	—	11	—	—	—	11
Segment earnings (losses)	$ 1,733	$ 361	$ 754	$ 74	$ 53	$ (901)	$ 2,074

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

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2017							
External revenues							
Premiums:							
Individual Medicare Advantage	$ 32,720	$ —	$ —	$ —	$ —	$ —	$ 32,720
Group Medicare Advantage	5,155	—	—	—	—	—	5,155
Medicare stand-alone PDP	3,702	—	—	—	—	—	3,702
Total Medicare	41,577	—	—	—	—	—	41,577
Fully-insured	478	5,462	—	947	—	—	6,887
Specialty	—	1,310	—	—	—	—	1,310
Medicaid and other	2,571	—	—	—	35	—	2,606
Total premiums	44,626	6,772	—	947	35	—	52,380
Services revenue:							
Provider	—	—	258	—	—	—	258
ASO and other	10	626	—	—	8	—	644
Pharmacy	—	—	80	—	—	—	80
Total services revenue	10	626	338	—	8	—	982
Total external revenues	44,636	7,398	338	947	43	—	53,362
Intersegment revenues							
Services	—	20	17,293	—	—	(17,313)	—
Products	—	—	6,292	—	—	(6,292)	—
Total intersegment revenues	—	20	23,585	—	—	(23,605)	—
Investment income	90	31	35	4	87	158	405
Total revenues	44,726	7,449	23,958	951	130	(23,447)	53,767
Operating expenses:							
Benefits	38,218	5,363	—	544	131	(760)	43,496
Operating costs	4,292	1,590	22,848	201	12	(22,376)	6,567
Merger termination fee and related costs, net	—	—	—	—	—	(936)	(936)
Depreciation and amortization	238	84	143	13	—	(100)	378
Total operating expenses	42,748	7,037	22,991	758	143	(24,172)	49,505
Income (loss) from operations	1,978	412	967	193	(13)	725	4,262
Interest expense	—	—	—	—	—	242	242
Income (loss) before income taxes and equity in net earnings	1,978	412	967	193	(13)	483	4,020
Equity in net earnings of Kindred at Home	—	—	—	—	—	—	—
Segment earnings (losses)	$ 1,978	$ 412	$ 967	$ 193	$ (13)	$ 483	$ 4,020

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

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life and annuities in run-off status and, prior to its sale in 2018, long-term care, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods used to determine future policy benefits payable as detailed in Note 2. Reinsurance recoverables, included in other current and long-term assets, were $267 million at December 31, 2019 and $314 million at December 31, 2018. The amount of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately $267 million at December 31, 2019 and approximately $313 million at December 31, 2018. Premiums ceded were $1 billion in 2019, $976 million in 2018 and $969 million in 2017. Benefits ceded were $881 million in 2019, $980 million in 2018, and $844 million in 2017. Historical ceded premium and benefits reflect the activity associated with ceding all risk under a Medicaid contract to a third party reinsurer. The reinsurance agreement ceding all risk under the Medicaid contract was terminated effective January 1, 2020.

We evaluate the financial condition of our reinsurers on a regular basis. Protective Life Insurance Company with $174 million in reinsurance recoverables is well-known and well-established with a AM Best rating of A+ (superior) at December 31, 2019 . The remaining reinsurance recoverables of $94 million are divided between 11 other reinsurers, with $72 million subject to funds withheld accounts or other financial guarantees supporting the repayment of these amounts.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Humana Inc. and its subsidiaries (the "Company") as of December 31, 2019 and 2018, and the related consolidated statements of income, of comprehensive income, of stockholders' equity and of cash flow for each of the three years in the period ended December 31, 2019, including the related notes and financial statement schedules listed in the index appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail,

accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Incurred but not yet Reported Benefits Payable

As described in Notes 2 and 11 to the consolidated financial statements, the Company's incurred but not yet reported benefits payable (IBNR) was $4.2 billion as of December 31, 2019. Management develops its estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. As described by management, for the periods prior to the most recent two months, the key assumption used in estimating IBNR is that the completion factor pattern remains consistent over a rolling 12-month period after adjusting for known changes in claim inventory levels and known changes in claim payment processes. For the most recent two months, IBNR is estimated primarily from a trend analysis based upon per member per month claims trends developed from historical experience in the preceding months, adjusted for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix and workday seasonality.

The principal considerations for our determination that performing procedures relating to the valuation of IBNR is a critical audit matter are there was significant judgment by management when developing the estimate of IBNR. This in turn led to a high degree of auditor judgment, subjectivity and effort in performing procedures and evaluating actuarial methodologies and significant assumptions, including completion factors and per member per month claims trends. Also, the audit effort involved the use of professionals with specialized skill and knowledge to assist in performing these procedures and evaluating the audit evidence obtained from these procedures.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of IBNR, including controls over the actuarial methodologies and development of significant assumptions related to completion factors and per member per month claims trends. These procedures also included, among others, involvement of professionals with specialized skill and knowledge to assist in developing an independent estimate of IBNR. This independent estimate includes a range of reasonable outcomes which are compared to management's estimate of IBNR. Developing the independent estimate involved developing independent completion factors and per member per month claims trends assumptions using management's data, testing the completeness and accuracy of data provided by management, and evaluating the reasonableness of management's assumptions.

Goodwill Impairment Assessment - Provider and Clinical Reporting Units

As described in Notes 2 and 9 to the consolidated financial statements, the Company's consolidated goodwill balance was $3.9 billion as of December 31, 2019, and the goodwill associated with the Provider and Clinical Reporting Units was $1.3 billion. Management conducts an impairment test in the fourth quarter of each year and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. Management relies on a discounted cash flow analysis to determine fair value and uses discount rates that correspond to a market-based weighted-average cost of capital, and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in management's cash flow projections, including revenue growth rates, medical and operating cost trends, and projected operating income, are consistent with those utilized in management's long-range business plan and annual planning process.

The principal considerations for our determination that performing procedures relating to the goodwill impairment assessment of the Provider and Clinical Reporting Units is a critical audit matter are there was significant judgment by management when developing the fair value estimate of the reporting units. This in turn led to a high degree of auditor judgment, subjectivity, and audit effort in performing procedures to evaluate management's cash flow projections, including significant assumptions for the revenue and terminal growth rates, projected operating income, and the discount rate. Also, the audit effort involved the use of professionals with specialized skill and knowledge to assist in performing these procedures and evaluating the audit evidence obtained from these procedures.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's goodwill impairment assessment, including controls over the significant assumptions used in the valuation of the Provider and Clinical Reporting Units. These procedures also included, among others, testing management's process for developing the fair value estimate of the reporting units; evaluating the appropriateness of the discounted cash flow analysis; testing the completeness and accuracy of underlying data used in the analysis; and evaluating the reasonableness of significant assumptions used by management, including the revenue and terminal growth rates and projected operating income, by considering the past performance of the reporting units and considering whether these assumptions were consistent with evidence obtained in other areas of the audit. Professionals with specialized skill and knowledge were used to assist in the evaluation of the appropriateness of the Company's discounted cash flow analysis and the reasonableness of the significant assumptions, including the terminal growth rates and the discount rate impacting the reporting units' future cash flows.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 20, 2020

We have served as the Company's auditor since 1968.

Humana Inc.
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31,2019 and 2018 follows:

	2019			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 16,107	$ 16,245	$ 16,241	$ 16,295
Income before income taxes and equity in net earnings	746	1,229	888	593
Net income	566	940	689	512
Basic earnings per common share (1)	$ 4.18	$ 6.96	$ 5.16	$ 3.87
Diluted earnings per common share (1)	$ 4.16	$ 6.94	$ 5.14	$ 3.84

	2018			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 14,279	$ 14,259	$ 14,206	$ 14,168
Income before income taxes and equity in net earnings	707	19	901	436
Net income	491	193	644	355
Basic earnings per common share (1)	$ 3.56	$ 1.40	$ 4.68	$ 2.60
Diluted earnings per common share (1)	$ 3.53	$ 1.39	$ 4.65	$ 2.58

(1) The calculation of earnings per common share is based on the weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2019, we as the principal executive officer, the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2019. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2019, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as ofDecember 31, 2019 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on page 120.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter endedDecember 31, 2019 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 23, 2020 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

A list of our executive officers and biographical information appears in Part I, Item 1 of this Form 10-K.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day (the "Code"). All employees and directors are required to annually affirm in writing their acceptance of the Code. The Code was adopted by our Board of Directors in June 2014, replacing a previous iteration, known as the Humana Inc. Principles of Business Ethics, as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Code is available on our web site at www.humana.com, and any waiver of the application of the Code with respect to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on our Internet web site is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our By-laws and Certificate of Incorporation;
- our Majority Vote policy;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;
- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;

- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 23, 2020.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 23, 2020 appearing under the caption "Corporate Governance – Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 23, 2020 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 23, 2020.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, and key employees. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2019 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	493,723	$ 250.460	19,627,620	(2)(3)(4)
Equity compensation plans not approved by security holders	—	—	—	
Total	493,723	$ 250.460	19,627,620	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 14.
(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) The Humana Inc. Amended and Restated Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 18, 2019. On May 1, 2019, 16 million shares were registered with the Securities and Exchange Commission on Form S-8.
(4) Of the number listed above, 6,388,331 (1,672,918 from the 2011 Plan and 4,715,413 from the Amended and Restated Plan) can be issued as restricted stock at December 31, 2019 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan and 3.35 stock options in the Amended and Restated Plan).

The information under the captions “Stock Ownership Information - Security Ownership of Certain Beneficial Owners of Company Common Stock” and “Stock Ownership Information - Security Ownership of Directors and Executive Officers” in our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 23, 2020, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 23, 2020 appearing under the captions “Certain Transactions with Management and Others” and “Corporate Governance – Director Independence” of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 23, 2020 appearing under the caption “Audit Committee Report” of such Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Condensed Financial Information at December 31, 2019 and 2018 and for the years ended December 31, 2019, 2018 and 2017
Schedule II	Valuation and Qualifying Accounts for the years ended December 31, 2019, 2018 and 2017

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) Humana Inc. Amended and Restated By-Laws of Humana Inc., effective as of December 14, 2017 (incorporated herein by reference to Exhibit 3(b) to Humana Inc.'s Current Report on Form 8-K filed on December 14, 2017).

4(a) Indenture, dates as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(b) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(c) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006, Req. No. 333-132878).

(d) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 13 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.

(e) Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(f) Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(g)	Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(h)	Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(i)	Tenth Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017).
(j)	Eleventh Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017).
(k)	Twelfth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017).
(l)	Thirteenth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017).
(m)	Fourteenth Supplemental Indenture, dated August 15, 2019, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on August 15, 2019).
(n)	Fifteenth Supplemental Indenture, dated August 15, 2019, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on August 15, 2019).
(o)†	Description of Securities.
10(a)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(b)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(c)*	Humana Inc. Executive Incentive Compensation Plan, as amended and restated January 1, 2020 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2019.
(d)*	Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999, File No. 001-05975).
(e)*	The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
(f)*	Humana Inc. Executive Severance Policy, effective as of March 1, 2019 (incorporated herein by reference to Exhibit 10(f) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(g)*	Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).

(h)* Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 18, 2011).

(i)* Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994, File No. 001-05975).

(j)* Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).

(k)* Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).

(l)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(m)* Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.

(n)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(q) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(o) Five-Year $2 Billion Amended and Restated Credit Agreement , dated as of May 22, 2017, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent and as CAF Loan Agent, Bank of America, N.A. as Syndication Agent, Citibank, N.A., PNC Bank, National Association, U.S. Bank National Association, and Wells Fargo Bank, National Association, as Documentation Agents, and J.P. Morgan Chase Bank, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Citigroup Global Markets, Inc., PNC Capital Markets LLC, U.S. Bank National Association, and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on May 22, 2017).

(p) Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(q) Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(r) Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(s) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(t) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(u) Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(v) Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005, File No. 001-05975).

(w)* Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).

(x)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(y)*	Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).
(z)*	Amendment No. 2, dated as of August 16, 2018, to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated as of February 27, 2014 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.s Current Report on Form 8-K, filed on August 20, 2018).
(aa)*	Humana Inc. Change in Control Policy, effective March 1, 2019 (incorporated herein by reference to Exhibit 10(aa) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(bb)	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 7, 2014).
(cc)	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(dd)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(ee)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K filed on February 16, 2018).
(ff)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(ff) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(gg)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(gg) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(hh)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(hh) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(ii)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10(ii) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(jj)*	Humana Inc. Compensation Recoupment Policy, effective February 21, 2019 (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(kk)*	Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 18, 2019).
(ll)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).

(mm)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(nn)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(oo)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(pp)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).
31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.
101	The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in iXBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2019 and 2018; (ii) the Consolidated Statements of Income for the years ended December 31, 2019, 2018 and 2017; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2019, 2018 and 2017; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2019, 2018, and 2017; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2019, 2018 and 2017; and (vi) Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.

*Exhibits 10(a) through and including 10(n), and Exhibits 10(w) through and including 10(aa), as well as Exhibits 10(cc) through and including Exhibit 10(pp) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Exchange Act, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2019	2018
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,006	$ 265
Investment securities	355	313
Receivable from operating subsidiaries	1,248	1,306
Other current assets	778	628
Total current assets	3,387	2,512
Property and equipment, net	1,403	1,209
Investments in subsidiaries	14,763	16,951
Equity method investment in Kindred at Home	1,063	1,047
Other long-term assets	778	359
Total assets	$ 21,394	$ 22,078
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 1,975	$ 4,487
Current portion of notes payable to operating subsidiaries	36	28
Book overdraft	40	38
Short-term debt	699	1,694
Other current liabilities	1,128	791
Total current liabilities	3,878	7,038
Long-term debt	4,967	4,375
Other long-term liabilities	512	504
Total liabilities	9,357	11,917
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,629,992 shares issued at December 31, 2019 and 198,594,841 shares issued at December 31, 2018	33	33
Capital in excess of par value	2,820	2,535
Retained earnings	17,483	15,072
Accumulated other comprehensive income (loss)	156	(159)
Treasury stock, at cost, 66,524,771 shares at December 31, 2019 and 63,028,169 shares at December 31, 2018	(8,455)	(7,320)
Total stockholders' equity	12,037	10,161
Total liabilities and stockholders' equity	$ 21,394	$ 22,078

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2019	2018	2017
	(in millions)		
Revenues:			
Management fees charged to operating subsidiaries	$ 1,789	$ 1,666	$ 1,864
Investment and other income, net	28	30	57
	1,817	1,696	1,921
Expenses:			
Operating costs	1,578	1,468	1,801
Merger termination fee and related costs, net	—	—	(936)
Depreciation	387	342	332
Interest	242	218	243
	2,207	2,028	1,440
Other (income) expense, net	(507)	33	—
Loss on sale of business	—	782	—
Income (loss) before income taxes and equity in net earnings of subsidiaries	117	(1,147)	481
Provision (benefit) for income taxes	27	(542)	61
Income (loss) before equity in net earnings of subsidiaries	90	(605)	420
Equity in net earnings of subsidiaries	2,603	2,277	2,028
Equity in net earnings of Kindred at Home	14	11	—
Net income	$ 2,707	$ 1,683	$ 2,448

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2019	2018	2017
	(in millions)		
Net income	$ 2,707	$ 1,683	$ 2,448
Other comprehensive income (loss):			
Change in gross unrealized investment losses/gains	450	(189)	149
Effect of income taxes	(105)	51	(55)
Total change in unrealized investment gains/losses, net of tax	345	(138)	94
Reclassification adjustment for net realized gains included in investment income	(34)	(53)	(14)
Effect of income taxes	8	17	5
Total reclassification adjustment, net of tax	(26)	(36)	(9)
Other comprehensive income (loss), net of tax	319	(174)	85
Comprehensive income attributable to our equity method investment in Kindred at Home	(4)	(4)	—
Comprehensive income	$ 3,022	$ 1,505	$ 2,533

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2019	2018	2017
	(in millions)		
Net cash provided by operating activities	$ 3,529	$ 2,719	$ 2,423
Cash flows from investing activities:			
Acquisitions, net of cash acquired	—	(354)	—
Acquisitions, equity method investment in Kindred at Home	—	(1,095)	—
Capital contributions to operating subsidiaries	(423)	(697)	(695)
Purchases of investment securities	(204)	(145)	(53)
Proceeds from sale of investment securities	15	35	—
Maturities of investment securities	134	59	51
Purchases of property and equipment, net	(585)	(465)	(359)
Net cash used in investing activities	(1,063)	(2,662)	(1,056)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	987	—	1,779
(Repayments) proceeds from issuance of commercial paper, net	(360)	485	(153)
Proceeds from term loan	—	1,000	—
Repayment of term loan	(650)	(350)	—
Repayment of long-term debt	(400)	—	(800)
Change in book overdraft	2	(3)	3
Common stock repurchases	(1,070)	(1,090)	(3,365)
Dividends paid	(291)	(265)	(220)
Proceeds from stock option exercises and other	57	48	62
Net cash used in financing activities	(1,725)	(175)	(2,694)
Increase (decrease) in cash and cash equivalents	741	(118)	(1,327)
Cash and cash equivalents at beginning of year	265	383	1,710
Cash and cash equivalents at end of year	$ 1,006	$ 265	$ 383

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $1.8 billion in 2019, $2.3 billion in 2018, and $1.4 billion in 2017.

Guarantee

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

3. REGULATORY REQUIREMENTS

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $8.0 billion and $7.6 billion as of December 31, 2019 and 2018, respectively, which exceeded aggregate minimum regulatory requirements of $5.9 billion and $5.2 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2020 is approximately $1 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $1.8 billion in 2019, $2.3 billion in 2018, and $1.4 billion in 2017.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Notes 3 and 4 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. During 2019, 2018 and 2017, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 13 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 16 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2019, 2018, and 2017
(in millions)

	Balance at Beginning of Period	Acquired/(Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2019	$ 79	$ —	$ (1)	$ —	$ (9)	$ 69
2018	96	—	36	(29)	(24)	79
2017	118	—	20	(10)	(32)	96
Deferred tax asset valuation allowance:						
2019	(54)	—	9	—	—	(45)
2018	(49)	—	(5)	—	—	(54)
2017	(49)	—	—	—	—	(49)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE

Brian A. Kane

Chief Financial Officer
(Principal Financial Officer)

Date: February 20, 2020

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Chief Financial Officer (Principal Financial Officer)	February 20, 2020
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 20, 2020
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 20, 2020
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 20, 2020
/s/ FRANK BISIGNANO **Frank Bisignano**	Director	February 20, 2020
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 20, 2020
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 20, 2020
/s/ WAYNE A. I. FREDERICK, M.D. **Wayne A. I. Frederick, M.D.**	Director	February 20, 2020
/s/ JOHN W. GARRATT **John W. Garratt**	Director	February 20, 2020
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 20, 2020
/s/ KAREN W. KATZ **Karen W. Katz**	Director	February 20, 2020
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 20, 2020
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 20, 2020
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 20, 2020

Exhibit 4(o)

DESCRIPTION OF REGISTRANT'S SECURITIES REGISTERED PURSUANT TO SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934

The following is a summary of information concerning our common stock, par value $.16 2/3 per share (the "common stock"). The summaries and descriptions below do not purport to be complete statements of, and are entirely qualified by, the relevant provisions of our Restated Certificate of Incorporation (the "certificate of incorporation") and Amended and Restated By-Laws (the "by-laws"), each of which is filed as an exhibit to our Annual Report on Form 10-K, and of the General Corporation Law of the State of Delaware (the "DGCL").

General

Our common stock is traded on the New York Stock Exchange under the symbol "HUM." The transfer agent and registrar for our common stock is American Stock Transfer & Trust Company.

Authorized Capital Stock

We are authorized to issue up to 300,000,000 shares of common stock, par value $.16 2/3 per share, and 10,000,000 shares of preferred stock, par value $1 per share. Without stockholder action, our board of directors is authorized to provide for the issuance of shares of preferred stock in one or more classes or series, to establish from time to time the number of shares to be included in each such class or series, to fix the designation, voting powers, preferences and relative, participating, options or other special rights of the shares of each such class or series and any qualifications, limitations or restrictions thereof.

Dividends

Subject to any preferential rights of any outstanding shares of our preferred stock, the holders of our common stock are entitled to receive, to the extent permitted by law, dividends as and when declared by our board of directors.

Liquidation

In the event of the liquidation or dissolution of our company, the holders of common stock will be entitled to receive ratably the balance of net assets available for distribution after payment of any liquidation or distribution preference payable with respect to any then outstanding shares of our preferred stock.

Voting Rights

Each share of our common stock is entitled to one vote with respect to matters brought before the stockholders. All voting is on a non-cumulative basis. All of our directors are elected at the annual meeting of our stockholders. Under our certificate of incorporation, neither our board of directors nor our stockholders may authorize the election of directors by cumulative voting or classify our directors by terms differing in dated of expiration without unanimous approval of our stockholders.

Our by-laws provide that nominees for director are elected by a majority vote standard in uncontested elections, and by a plurality vote standard in contested elections. We have a resignation policy applicable to any nominee who is an incumbent director who fails to be re-elected in an uncontested election. Any director may be removed from office, either with or without cause, by the affirmative vote of the holders of a majority of all of the shares of stock outstanding and entitled to vote for the election of directors.

Other Rights

There are no preemptive, conversion, redemption or sinking fund provisions applicable to our common stock. The rights and privileges of our common stock will be subordinate to the rights and preferences of any shares of our preferred stock that we may issue in the future.

Fully Paid and Non-Assessable

The outstanding shares of our common stock are fully paid and non-assessable.

Proxy Access

Our by-laws permit a stockholder, or a group of up to 20 stockholders, owning at least three percent of our outstanding common stock continuously for at least three years to nominate and include in our annual meeting proxy materials director nominees constituting up to the greater of two directors or twenty percent of our board of directors, provided that the stockholders and nominees satisfy the requirements specified in our by-laws.

Anti-Takeover Effects of Delaware Law and Certain Provisions of Our Certificate of Incorporation and By-Laws

The provisions of Delaware law, our certificate of incorporation and by-laws may have the effect of delaying, deferring or discouraging another person from acquiring control of our company, including takeover attempts that might result in a premium over the market price for the shares of common stock. These provisions, described below, could deprive the stockholders of opportunities to realize a premium on the shares of our common stock owned by them.

Delaware Anti-Takeover Statute

Section 203 of the DGCL prohibits a publicly held Delaware corporation from engaging in a business combination with an interested stockholder for a period of three years after the time that the person became an interested stockholder, unless the business combination or the transaction in which such person became an interested stockholder is approved in a prescribed manner or another prescribed exemption applies. Generally, a "business combination" is defined to include mergers, asset sales, and other transactions resulting in financial benefit to a stockholder, and an " interested stockholder" is defined as any person or entity, together with its affiliates and associates, that is, at any time within the past three years was, the beneficial owner of at least 15% of a corporation's outstanding voting stock. The statute could prohibit or delay mergers or other takeovers or change-in-control attempts and, accordingly, may discourage attempts to acquire us.

Voting Requirements for Business Combinations

The DGCL generally provides that, subject to certain exceptions, the affirmative vote of a majority of the shares of a Delaware corporation entitled to vote on any matter is required to approve mergers, consolidations or the sale of all or substantially all of such corporation's assets unless otherwise provided in such corporation's certificate of incorporation.

Article Eleventh of our certificate of incorporation provides that the affirmative vote of three-fourths of our outstanding shares entitled to vote thereon will be required for our stockholders to:

- adopt any agreement for the merger or consolidation of us with or into a related company or an affiliate of a related company;
- authorize the sale or lease of all or substantially all of our assets to a related company or affiliate of a related company; or
- authorize the sale or lease to us or any of our subsidiaries of any assets of a related company or an affiliate of a related company in exchange for our equity securities.

The foregoing provision is not applicable to any such transaction if our board of directors approves the applicable transaction with a related company or affiliate prior to the time that the related company or affiliate became a holder of more than 5% of any class of our equity securities.

Under Article Eleventh of our certificate of incorporation,

- a "related company" in respect of any given transaction is any company, person or other entity which by itself or together with its affiliates and associates is the beneficial owner, directly or indirectly, of more than 5% of any class of our equity securities as of the record date for the determination of stockholders entitled to vote on such transactions;
- an "affiliate" of a related company is any company, person or other entity which, directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the related company; and
- an "associate" of a related company is any officer, director or beneficial owner, directly or indirectly, of 5% or more of any class of equity securities of such related company or any of its affiliates.

The provisions of Article Eleventh of our certificate of incorporation may not be amended without the affirmative vote of three-fourths of our outstanding shares entitled to vote thereon.

Advanced Notice Procedures for Stockholder Proposals and Director Nominations

Our by-laws set forth advance notice provisions with respect to stockholders seeking to bring business before an annual meeting of stockholders, or to nominate candidates for election as directors at an annual meeting of stockholders or special meeting of stockholders called by our board of directors for that purpose. Our by-laws also specify various requirements as to the timing, form and content of a stockholder's notice.

Special Meetings

Special meetings of our stockholders may be held if our board of directors, its chairman, our chief executive officer or our president calls a meeting. However, these persons must call a meeting if stockholders owning one-fourth of our shares then issued and outstanding and entitled to vote on matters to be submitted to our stockholders request in writing that a meeting be held, subject to certain requirements specified in our by-laws.

Preferred Stock

The ability of our board of directors to establish the rights and issue substantial amounts of preferred stock without the need for stockholder approval, while providing desirable flexibility in connection with possible acquisitions, financings and other corporate transactions, may discourage, delay, defer or prevent a change of control of us.

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ARKANSAS
1. Humana Regional Health Plan, Inc.

CALIFORNIA
1. Humana EAP and Work-Life Services of California, Inc.
2. Humana Health Plan of California, Inc.

DELAWARE
1. Atlantis Physician Group, LLC
2. CDO 1, LLC
3. CDO 2, LLC
4. CompBenefits Corporation
5. CompBenefits Direct, Inc.
6. Conviva Care Solutions, LLC
7. Edge Health MSO, Inc.
8. Emphesys, Inc.
9. FPG Acquisition Corp.
10. FPG Acquisition Holdings Corp.
11. FPG Holding Company, LLC
12. Go365, LLC
13. Health Value Management, Inc.
14. HUM Provider Holdings, LLC
15. Humana at Home, Inc.
16. Humana Digital Health and Analytics Platform Services, Inc.
17. Humana Government Business, Inc.
18. Humana Inc.
19. Humana Innovation Enterprises, Inc.
20. Humana Pharmacy, Inc.
21. Humana Veterans Healthcare Services, Inc.
22. Humana WellWorks LLC
23. HumanaDental, Inc.
24. MCCI Group Holdings, LLC
25. MCCI Holding, LLC
26. North Region Providers, LLC
27. Primary Care Holdings, Inc.
28. Primary Care Holdings II, LLC
29. Transcend Population Health Management, LLC
30. Transcend Population Health Management II, LLC

FLORIDA
1. 154th Street Medical Plaza, Inc.
2. 54th Street Medical Plaza, Inc.
3. CAC Medical Center Holdings, Inc.
4. CAC-Florida Medical Centers, LLC
5. Care Partners Home Care, LLC
6. CarePlus Health Plans, Inc.
7. CompBenefits Company
8. Complex Clinical Management, Inc.
9. Continucare Corporation
10. Continucare MDHC, LLC
11. Continucare Medical Management, Inc.
12. Family Physicians of Winter Park, Inc.
13. FPG Senior Services, LLC
14. HUM-e-FL, Inc.
15. Humana At Home 1, Inc.

16. Humana Dental Company
17. Humana Health Insurance Company of Florida, Inc.
18. Humana Medical Plan, Inc.
19. MCCI Specialty, LLC
20. MCCI/Lifetime of Aventura, LLC
21. METCARE of Florida, Inc.
22. Metropolitan Health Networks, Inc.
23. Naples Health Care Specialists, LLC
24. Nursing Solutions, LLC
25. Partners in Integrated Care, Inc.
26. Primary Care Specialists of the Palm Beaches, LLC
27. RMA Island Doctors Orlando MSO, LLC
28. RMA Medical Center of Orlando, LLC
29. RMA Medical Center of South Orlando, LLC
30. RMA Medical Center of Sunrise, LLC
31. RMA Medical Centers of Florida, LLC
32. RMA Medical Group of Florida, LLC
33. SeniorBridge Family Companies (FL), Inc.
34. SeniorBridge-Florida, LLC

GEORGIA
1. Humana Employers Health Plan of Georgia, Inc.

ILLINOIS
1. CompBenefits Dental, Inc.
2. Dental Care Plus Management, Corp.
3. Humana Benefit Plan of Illinois, Inc.
4. Humana Healthcare Research, Inc.

INDIANA
1. SeniorBridge Family Companies (IN), Inc.

KENTUCKY
1. 516-526 West Main Street Condominium Council of Co-Owners, Inc.
2. CHA HMO, Inc.
3. Humana Active Outlook, Inc.
4. Humana Health Plan, Inc.
5 Humana Insurance Company of Kentucky
6. Humana MarketPOINT, Inc.
7. Humana Pharmacy Solutions, Inc.
8. Humana Real Estate Company
9. Humco, Inc.
10. The Dental Concern, Inc.

LOUISIANA
1. Humana Health Benefit Plan of Louisiana, Inc.

MICHIGAN
1. Humana Medical Plan of Michigan, Inc.

NEW YORK
1. Harris, Rothenberg International Inc.
2. Humana Health Company of New York, Inc.
3. Humana Insurance Company of New York
4. SeniorBridge Family Companies (NY), Inc.

OHIO
1. Humana Health Plan of Ohio, Inc.

2. Hummingbird Coaching Systems LLC

PENNSYLVANIA
1. Humana Medical Plan of Pennsylvania, Inc.

PUERTO RICO
1. Humana Health Plans of Puerto Rico, Inc.
2. Humana Insurance of Puerto Rico, Inc.
3. Humana Management Services of Puerto Rico, Inc.
4. Humana MarketPOINT of Puerto Rico, Inc.

South Carolina
1. Humana Benefit Plan of South Carolina, Inc.

TENNESSEE
1. Cariten Health Plan Inc.
2. PHP Companies, Inc.
3. Preferred Health Partnership, Inc.

TEXAS
1. CompBenefits Insurance Company
2. DentiCare, Inc.
3. Emphesys Insurance Company
4. Humana At Home (Dallas), Inc.
5. Humana At Home (Houston), Inc.
6. Humana At Home (San Antonio), Inc.
7. Humana At Home (TLC), Inc.
8. Humana Benefit Plan of Texas, Inc.
9. Humana Health Plan of Texas, Inc.
10. Medical Care Consortium Incorporated of Texas
11. ROHC, L.L.C.
12. Texas Dental Plans, Inc.

UTAH
1. Humana Medical Plan of Utah, Inc.

VERMONT
1. Managed Care Indemnity, Inc.

WASHINGTON
1. Arcadian Health Plan, Inc.

WISCONSIN
1. CareNetwork, Inc.
2. Humana Insurance Company
3. Humana Wisconsin Health Organization Insurance Corporation
4. HumanaDental Insurance Company
5. Independent Care Health Plan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on FormS-8 (No. 33-49305, No. 333-04435, No. 333-57095, No. 333-86801, No. 333-41408, No. 333-86280, No. 333-105622, No. 333-134887, No. 333-162747, No. 333-171616, and No. 333-175350) and S-3 (No. 333-223554) of Humana Inc. of our report dated February 20, 2020 relating to the financial statements and financial statement schedulesand the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

February 20, 2020

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Bruce D. Broussard, principal executive officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2020

Signature: /s/ BRUCE D. BROUSSARD

Bruce D. Broussard
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Brian A. Kane, principal financial officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2020

Signature: /s/ BRIAN A. KANE

Brian A. Kane
Principal Financial Officer

Exhibit 32

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Humana Inc. (the "Company") on Form 10-K for the period ended December 31, 2019 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ BRUCE D. BROUSSARD

Bruce D. Broussard
President and Chief Executive Officer,
Director (Principal Executive Officer)

February 20, 2020

/s/ BRIAN A. KANE

Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

February 20, 2020

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

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

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2018
OR

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

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

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

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

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

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

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company,"and "emerging growth company" in Rule 12b-2 of the Exchange Act.

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

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2018 was $41,129,697,151 calculated using the average price on June 30, 2018 of $299.02.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2019 was 135,566,909.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 18, 2019.

HUMANA INC.
INDEX TO ANNUAL REPORT ON FORM 10-K
For the Year Ended December 31, 2018

		Page
	Part I	
Item 1.	Business	3
Item 1A.	Risk Factors	17
Item 1B.	Unresolved Staff Comments	31
Item 2.	Properties	32
Item 3.	Legal Proceedings	33
Item 4.	Mine Safety Disclosures	33
	Part II	
Item 5.	Market for the Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	34
Item 6.	Selected Financial Data	37
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	38
Item 7A.	Quantitative and Qualitative Disclosures about Market Risk	76
Item 8.	Financial Statements and Supplementary Data	78
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	136
Item 9A.	Controls and Procedures	136
Item 9B.	Other Information	137
	Part III	
Item 10.	Directors, Executive Officers and Corporate Governance	138
Item 11.	Executive Compensation	141
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	141
Item 13.	Certain Relationships and Related Transactions, and Director Independence	142
Item 14.	Principal Accounting Fees and Services	142
	Part IV	
Item 15.	Exhibits, Financial Statement Schedules	143
Item 16.	Form 10-K Summary	155
	Signatures and Certifications	156

Forward-Looking Statements

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

PART I

ITEM 1. BUSINESS

General

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

As of December 31, 2018, we had approximately 17 million members in our medical benefit plans, as well as approximately 6 million members in our specialty products. During 2018, 81% of our total premiums and services revenue were derived from contracts with the federal government, including 15% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 636,800 members as of December 31, 2018.

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

This Annual Report on Form 10-K, or 2018 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2018 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Business Segments

We manage our business with four reportable segments: Retail, Group and Specialty, Healthcare Services, and Individual Commercial. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources. See Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

Our Products

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

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2018:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 35,656	63.2%
Group Medicare Advantage	6,103	10.8%
Medicare stand-alone PDP	3,584	6.4%
Total Retail Medicare	45,343	80.4%
State-based Medicaid	2,255	4.0%
Medicare Supplement	510	0.9%
Total premiums	48,108	85.3%
Services	11	—%
Total premiums and services revenue	$ 48,119	85.3%

Medicare

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

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

Individual Medicare Advantage Products

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

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

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

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. For more information refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data and Item 1A. - Risk Factors.

At December 31, 2018, we provided health insurance coverage under CMS contracts to approximately 3,064,000 individual Medicare Advantage members, including approximately 636,800 members in Florida. These Florida contracts accounted for premiums revenue of approximately $8.2 billion, which represented approximately 23.0% of our individual Medicare Advantage premiums revenue, or 14.6% of our consolidated premiums and services revenue for the year ended December 31, 2018.

Our HMO, PPO, and PFFS products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2019, and all of our product offerings filed with CMS for 2019 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, titled "Medicare Part D." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2019, and all of our product offerings filed with CMS for 2019 have been approved.

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

Group Medicare Advantage and Medicare stand-alone PDP

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

State-based Medicaid Contracts

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

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

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. States require special coordinating contracts for plans to offer Medicare Advantage dual eligible special needs plans, or D-SNPs. These largely operate separate from traditional Medicaid and LTSS programs. Some states are moving to support the dual eligible population by linking D-SNP participation to enrollment in a plan that also participates in a state-based Medicaid program to coordinate and integrate both Medicare and Medicaid benefits. Beginning in 2021, based on new federal requirements, D-SNPs will be required to more fully integrate Medicare and Medicaid benefits and states will have authority to require linkages to state-based traditional Medicaid and/or LTSS contracts or alternatively, allow D-SNPs to operate without a link to such state-based contracts while meeting additional coordination standards; CMS has yet to finalize regulations.

We currently serve dual eligible members under the CMS stand-alone dual eligible demonstration program in Illinois, and continue to serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans.

Our Group and Specialty Segment Products

The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision and life insurance benefits, as well as administrative services only, or ASO products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group and Specialty segment by product for the year ended December 31, 2018:

	Group and Specialty Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 5,444	9.7%
Specialty	1,359	2.4%
Total premiums	6,803	12.1%
Services	835	1.5%
Total premiums and services revenue	$ 7,638	13.6%
Intersegment services revenue	$ 18	n/a

n/a – not applicable

Group Commercial Coverage

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

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

Employers can customize their offerings with optional benefits such as dental, vision, and life products. We also offer optional benefits such as dental and vision to individuals.

Military Services

Under our TRICARE contracts with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. Under our contracts, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. On January 1, 2018, we began to deliver services under the T2017 East Region contract. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, clinical care services, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2018:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 20,514	n/a
Provider services	1,994	n/a
Clinical care services	662	n/a
Total intersegment revenue	$ 23,170	
External services revenue:		
Pharmacy solutions	$ 203	0.4%
Provider services	228	0.4%
Clinical care services	176	0.3%
Total external services revenue	$ 607	1.1%

n/a – not applicable

Pharmacy solutions

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

Provider services

We operate full-service, multi-specialty medical centers in a number of states, primarily in Florida and Texas, staffed by primary care providers and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry. Our care delivery subsidiaries operate our medical center business through both employed physicians and care providers, and through third party management service organizations with whom we contract to arrange for and manage certain clinical services.

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

During 2018, we acquired the remaining equity interest in MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. In addition, during 2018, we acquired Family Physicians Group, or FPG, which serves Medicare Advantage and Managed Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Clinical care services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Clinical care services include the operations of Humana At Home, Inc., or Humana At Home®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. At December 31, 2018, we have enrolled approximately 716,000 members, with complex chronic conditions participating in a Humana Chronic Care Program, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. These members may not be unique to each program since members have the ability to enroll in multiple programs. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

We have committed additional investments in our home care capabilities with our acquisition of a 40% minority interest in Kindred at Home, Inc., or Kindred at Home, and Curo Health Services, or Curo, which combined creates the nation's largest home health and hospice provider with 65% overlap with our individual Medicare Advantage business. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management and wellness programs. These programs use our capabilities that enable us to create a more complete view of an individual’s health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

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

Wellness

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

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

Our Individual Commercial Segment Products

Our individual health plans were marketed under the HumanaOne brand. We offered products both on and off of the public exchange.

We discontinued substantially all off-exchange individual commercial medical plans effective January 1, 2017, and we exited our remaining individual commercial medical business effective January 1, 2018.

Other Businesses

Other Businesses includes those businesses that do not align with the reportable segments previously described, primarily our closed-block long-term care insurance policies, which was sold in 2018. For a detailed discussion of the sale refer to Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Membership

The following table summarizes our total medical membership at December 31, 2018, by market and product:

	Retail Segment				Group and Specialty Segment					
	(in thousands)									
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Total	Percent of Total
Florida	636.8	9.9	234.2	11.4	333.4	125.7	36.2	—	1,387.6	8.4%
Texas	246.9	241.9	305.1	10.6	—	171.6	30.4	—	1,006.5	6.1%
Kentucky	89.0	63.7	215.6	5.8	—	112.6	138.5	—	625.2	3.8%
California	70.9	0.2	484.4	20.3	—	—	—	—	575.8	3.5%
Georgia	114.2	2.2	124.5	11.1	—	158.5	45.2	—	455.7	2.7%
Illinois	108.7	23.3	185.2	5.7	7.7	46.0	76.8	—	453.4	2.7%
Ohio	128.6	22.1	184.3	45.8	—	44.6	27.5	—	452.9	2.7%
Missouri/Kansas	82.5	4.9	227.2	9.1	—	45.0	17.4	—	386.1	2.3%
North Carolina	149.5	0.5	172.6	6.0	—	—	—	—	328.6	2.0%
Tennessee	144.3	4.3	117.2	4.9	—	41.4	12.9	—	325.0	2.0%
Louisiana	161.1	12.1	61.3	2.2	—	59.6	13.5	—	309.8	1.9%
Wisconsin	58.7	10.0	121.6	6.3	—	68.7	36.8	—	302.1	1.8%
Indiana	103.5	6.8	145.8	9.0	—	21.2	12.6	—	298.9	1.8%
Virginia	121.6	3.1	159.1	8.6	—	—	—	—	292.4	1.8%
Michigan	52.9	12.9	140.2	3.4	—	2.8	0.4	—	212.6	1.3%
Arizona	76.0	0.4	97.6	4.8	—	25.0	5.5	—	209.3	1.3%
Pennsylvania	46.6	0.4	156.2	4.7	—	—	—	—	207.9	1.2%
South Carolina	87.0	0.5	71.3	5.2	—	—	—	—	164.0	1.0%
Military services	—	—	—	—	—	—	—	5,928.6	5,928.6	35.8%
Others	585.2	78.6	1,800.9	79.4	—	82.0	28.2	—	2,654.3	15.9%
Totals	3,064.0	497.8	5,004.3	254.3	341.1	1,004.7	481.9	5,928.6	16,576.7	100.0%

Provider Arrangements

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

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

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

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

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

Capitation

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

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

At December 31, 2018, approximately 1,128,500 members, or 6.8% of our medical membership, were covered under risk-based contracts, which provide all member benefits, including 942,000 individual Medicare Advantage members, or 30.7% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and monitor the financial performance and solvency of our capitated providers. However, we delegated claim processing functions under capitation arrangements covering approximately 181,200 HMO members, including 168,900 individual Medicare Advantage members, or 17.9% of the 942,000 individual Medicare Advantage members covered under risk-based contracts at December 31, 2018, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $1.5 billion, or 3.3% of total benefits expense, for the year ended December 31, 2018. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Set, or HEDIS, which is used by employers, government purchasers and the National

Committee for Quality Assurance (NCQA) to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

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

Recredentialing of participating providers occurs every three years, unless otherwise required by state or federal regulations. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee composed of a peer group of providers reviews the applications of providers being considered for credentialing and recredentialing.

We maintain accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), and/or URAC. All Federal Employee Health Benefit Plans are required to be accredited. Certain commercial businesses, such as those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, population health management, credentialing, utilization management, network management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in many of our commercial, Medicare and Medicaid HMO/POS and PPO markets and our wellness program, Go365. Humana's pharmacy organization is accredited by URAC.

Sales and Marketing

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

At December 31, 2018, we employed approximately 1,500 sales representatives, as well as approximately 1,400 telemarketing representatives who assisted in the marketing of Medicare, including Medicare Advantage and PDP, in our Retail segment and specialty products in our Group and Specialty segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group and Specialty segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. We use licensed independent brokers, independent agents, digital insurance agencies, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our specialty products.

Underwriting

Since 2014, the Patient Protection and Affordability Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Health Care Reform Law, requires certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2018 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system, including the Health Care Reform Law.

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

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2018 Form 10-K.

Certain Other Services

Captive Insurance Company

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

Centralized Management Services

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

Employees

As of December 31, 2018, we had approximately 41,600 employees and approximately 2,000 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

Risks Relating to Our Business

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

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

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

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to

appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

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

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

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

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

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

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

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

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

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 80% of our total premiums and services revenue for the year ended December 31, 2018 generated from our Medicare products, including 15% derived from our individual Medicare Advantage contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

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

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

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

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

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

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the

software industry, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

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

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

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. We have been, and will likely continue to be, regular targets of attempted cybersecurity attacks and other security threats and may be subject to breaches of our information technology security systems. Although the impact of such attacks has not been material to our operations or results of operations, financial position, or cash flow through December 31, 2018, we can provide no assurance that we will be able to detect, prevent, or contain the effects of such cybersecurity attacks or other information security risks or threats in the future. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our businesses whose operations are subject to similar risks.

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

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

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

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

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;

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

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

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

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

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

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

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 85% of our total premiums and services revenue for the year ended December 31, 2018. These programs involve various risks, as described further below.

- At December 31, 2018, under our contracts with CMS we provided health insurance coverage to approximately 636,800 individual Medicare Advantage members in Florida. These contracts accounted for

approximately 15% of our total premiums and services revenue for the year ended December 31, 2018. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

- At December 31, 2018, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2018, primarily consisted of the TRICARE T2017 East Region contract replacing the 5-year T3 South Region contract that expired on December 31, 2017. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5 -year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option. The loss of the TRICARE T2017 East Region contract may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.
- CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

  CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic

differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

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

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We are studying the Proposed Rule and CMS' underlying analysis contained therein. We believe, however, that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and we expect to provide substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. We are also evaluating the potential impact of the Proposed Rule, and any related regulatory, industry or company reactions, all or any of which could have a material adverse effect on our results of operations, financial position, or cash flows.

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

We believe that CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has filed a motion for reconsideration related to certain aspects of the Federal District Court's opinion and has simultaneously filed a notice to appeal the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

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

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $170 million and $279 million at December 31, 2018 and 2017, respectively.

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

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

- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations, including audits of risk adjustment data, are also conducted by state attorneys

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

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

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

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

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

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

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

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

These regulations set standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

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

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

American Recovery and Reinvestment Act of 2009 (ARRA)

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

Corporate Practice of Medicine and Other Laws

As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-

splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows.

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

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

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

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

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

Environmental

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

State Regulation of Insurance-Related Products

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

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

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

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

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

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

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive

disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

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

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

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

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

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

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

business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

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

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

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

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

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

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

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

We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would

increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected.

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

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

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

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

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2018:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	13	207	—	69	289
Texas	1	17	2	14	34
Kentucky	2	3	15	12	32
Arizona	—	17	—	6	23
Louisiana	—	6	—	10	16
Virginia	—	8	—	7	15
Illinois	—	5	—	10	15
California	—	2	—	12	14
Ohio	—	1	—	13	14
South Carolina	—	6	—	6	12
New York	—	—	—	13	13
Nevada	—	7	—	5	12
Puerto Rico	—	1	—	10	11
Indiana	—	5	—	5	10
Georgia	—	8	—	3	11
Washington	—	7	—	4	11
Tennessee	—	—	—	9	9
New Jersey	—	—	—	9	9
Colorado	—	5	—	3	8
Michigan	—	5	—	3	8
North Carolina	—	2	—	4	6
Others	—	9	1	38	48
Total	16	321	18	265	620

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of the medical centers included in the table above, approximately 44 of these facilities are leased or subleased to our contracted providers to operate.

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

ITEM 3. LEGAL PROCEEDINGS

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

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM.

Holders of our Capital Stock

As of January 31, 2019, there were approximately 2,300 holders of record of our common stock and approximately 244,700 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2017 and 2018, under our Board approved quarterly cash dividend policy:

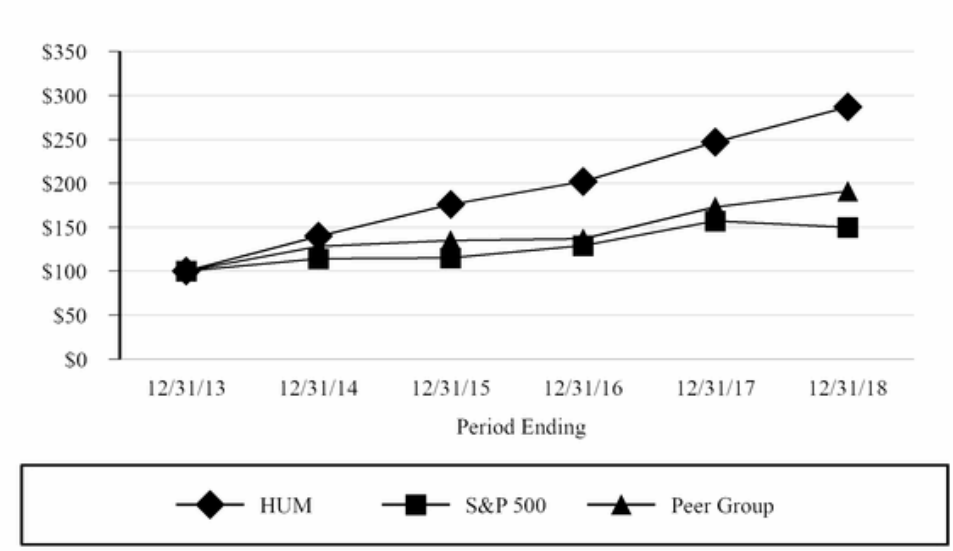
Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2017 payments			
1/12/2017	1/27/2017	$0.29	$43
3/31/2017	4/28/2017	$0.40	$58
6/30/2017	7/31/2017	$0.40	$58
9/29/2017	10/27/2017	$0.40	$57
2018 payments			
12/29/2017	1/26/2018	$0.40	$55
3/30/2018	4/27/2018	$0.50	$69
6/29/2018	7/27/2018	$0.50	$69
9/28/2018	10/26/2018	$0.50	$69

On November 2, 2018, the Board declared a cash dividend of $0.50 per share that was paid on January 25, 2019 to stockholders of record on December 31, 2018, for an aggregate amount of $68 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2019, the Board declared a cash dividend of $0.55 per share payable on April 26, 2019 to stockholders of record on March 29, 2019.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2018. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2013, and that dividends were reinvested when paid.



	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
HUM	$ 100	$ 140	$ 176	$ 202	$ 247	$ 287
S&P 500	$ 100	$ 114	$ 115	$ 129	$ 157	$ 150
Peer Group	$ 100	$ 128	$ 135	$ 137	$ 173	$ 191

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

Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2018 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1) (2)
October 2018	—	$ —	—	$ 1,776,354,011
November 2018	1,937,797	309.63	1,937,797	1,176,354,010
December 2018	—	—	—	1,176,354,010
Total	1,937,797	$ 309.63	1,937,797	

(1) On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans. Under the share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions, including pursuant to accelerated share repurchase agreements with investment banks, subject to certain regulatory restrictions on volume, pricing, and timing. On November 28, 2018, we entered into an accelerated stock repurchase agreement, the November 2018 ASR, with Goldman, Sachs & Co. LLC, or Goldman Sachs, to repurchase $750 million of our common stock as part of the $3.0 billion share repurchase program authorized by the Board of Directors on December 14, 2017. On November 29, 2018, we made a payment of $750 million to Goldman Sachs from available cash on hand and received an initial delivery of 1.94 million shares of our common stock from Goldman Sachs. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of an $600 million increase in treasury stock, which reflects the value of the initial 1.94 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the November 2018 ASR. Our remaining repurchase authorization was approximately $1,176 million as of February 21, 2019, excluding the $150 million pending final settlement of our November 2018 ASR.

(2) Excludes 0.15 million shares repurchased in connection with employee stock plans.

ITEM 6. SELECTED FINANCIAL DATA

	2018	2017	2016 (a)	2015	2014
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$ 54,941	$ 52,380	$ 53,021	$ 52,409	$ 45,959
Services	1,457	982	969	1,406	2,164
Investment income	514	405	389	474	377
Total revenues	56,912	53,767	54,379	54,289	48,500
Operating expenses:					
Benefits	45,882	43,496	45,007	44,269	38,166
Operating costs	7,525	6,567	7,173	7,295	7,639
Merger termination fee and related costs, net	—	(936)	104	23	—
Depreciation and amortization	405	378	354	355	333
Total operating expenses	53,812	49,505	52,638	51,942	46,138
Income from operations	3,100	4,262	1,741	2,347	2,362
Loss (gain) on sale of business	786	—	—	(270)	—
Interest expense	218	242	189	186	192
Other expense, net	33	—	—	—	—
Income before income taxes and equity in net earnings	2,063	4,020	1,552	2,431	2,170
Provision for income taxes	391	1,572	938	1,155	1,023
Equity in net earnings of Kindred at Home	11	—	—	—	—
Net income	$ 1,683	$ 2,448	$ 614	$ 1,276	$ 1,147
Basic earnings per common share	$ 12.24	$ 16.94	$ 4.11	$ 8.54	$ 7.44
Diluted earnings per common share	$ 12.16	$ 16.81	$ 4.07	$ 8.44	$ 7.36
Dividends declared per common share	$ 2.00	$ 1.60	$ 1.16	$ 1.15	$ 1.11
Financial Position:					
Cash and investments	$ 12,780	$ 16,344	$ 13,675	$ 11,681	$ 11,482
Total assets	25,413	27,178	25,396	24,678	23,497
Benefits payable	4,862	4,668	4,563	4,976	4,475
Debt	6,069	4,920	4,092	4,093	3,795
Stockholders' equity	10,161	9,842	10,685	10,346	9,646
Cash flows from operations	$ 2,173	$ 4,051	$ 1,936	$ 868	$ 1,618
Key Financial Indicators:					
Benefit ratio	83.5%	83.0%	84.9%	84.5%	83.0%
Operating cost ratio	13.3%	12.3%	13.3%	13.6%	15.9%
Membership by Segment:					
Retail segment:					
Medical membership	9,161,500	9,206,300	8,751,300	8,327,700	7,360,300
Group and Specialty segment:					
Medical membership	7,415,200	4,638,200	4,793,300	4,963,400	5,430,200
Specialty membership	6,072,300	6,986,000	6,961,200	7,221,800	7,668,500
Individual commercial segment:					
Medical membership	—	128,800	654,800	899,100	1,016,200
Other Businesses:					
Medical membership	—	29,800	30,800	32,600	35,000
Consolidated:					
Total medical membership	16,576,700	14,003,100	14,230,200	14,222,800	13,841,700
Total specialty membership	6,072,300	6,986,000	6,961,200	7,221,800	7,668,500

(a) Includes a reduction in premiums revenue of $583 million ($367 million after tax, or $2.43 per diluted common share) associated with the write-off of commercial risk corridor receivables. Also includes benefits expense of $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies, which were sold in 2018.

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

Executive Overview

General

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

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

Business Segments

We manage our business with four reportable segments: Retail, Group and Specialty, Healthcare Services, and Individual Commercial. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources. See Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes our services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our investment in Kindred at Home. The Individual Commercial segment consisted of our individual commercial fully-insured medical health insurance business, which we exited beginning January 1, 2018. We report under the category of Other Businesses those businesses that do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies, which were sold in 2018.

The results of each segment are measured by income before income taxes and equity in net earnings from Kindred at Home, or segment earnings. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail and Group and Specialty segment customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and

certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations.

Seasonality

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

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

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

Aetna Merger

On February 16, 2017, under the terms of the Agreement and Plan of Merger, or Merger Agreement, with Aetna Inc., and certain wholly owned subsidiaries of Aetna Inc., which we collectively refer to as Aetna, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned "Merger termination fee and related costs, net."

Acquisitions and Divestitures

On August 9, 2018, we completed the sale of our wholly-owned subsidiary, KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, includes our closed block of non-strategic commercial long-term care policies. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. In connection with the sale of KMG, we recognized a pretax loss, including transaction costs, of $786 million and a corresponding $452 million tax benefit. Prior to the sale of KMG, we entered into reinsurance contracts to transfer the risk associated with certain voluntary benefit and financial protection products previously issued primarily by KIC to a third party. We transferred approximately $245 million of cash to the third party and recorded a commensurate reinsurance recoverable as a result of these transactions. The reinsurance recoverable was included as part of the net assets disposed. There was no material impact to operating results from these reinsurance transactions.

On July 2, 2018 and July 11, 2018, we along with TPG Capital, or TPG, and Welsh, Carson, Anderson & Stowe, or WCAS, collectively, the Sponsors, completed the acquisitions of Kindred and Curo, respectively, merging Curo with the hospice business of Kindred at Home. As part of these transactions, we acquired a 40% minority interest in the combined business, Kindred at Home, a for total cash consideration of approximately $1.1 billion.

On April 10, 2018, we acquired Family Physicians Group, or FPG, for cash consideration of approximately $185 million, net of cash received. FPG is one of the largest at-risk providers serving Medicare Advantage and Managed

Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties.

On March 1, 2018, we acquired the remaining equity interest in MCCI Holdings LLC, or MCCI, a privately held management service organization headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. The purchase price consisted primarily of $169 million cash, as well as our existing investment in MCCI and a note receivable and a revolving note with an aggregate balance of $383 million.

These transactions are more fully discussed in Note 3 to the consolidated financial statements.

Highlights

Consolidated

- Our 2018 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2018, approximately 2,039,100 members, or 67%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 1,901,300 members, or 66%, at December 31, 2017.
- Our consolidated pretax income was $2.06 billion for 2018 compared to $4.02 billion in 2017. A number of significant items effected our year-over-year comparisons including the following:
    - The net gain associated with the terminated Merger Agreement, mainly the break-up fee of $936 million in 2017.
    - The loss on sale of KMG of $786 million in 2018.
    - Charges in 2017 of $219 million associated with voluntary and involuntary workforce reduction programs, the Penn Treaty guaranty fund assessment and costs associated with the early retirement of debt.
    - Lower year-over-year segment earnings in our Retail, Group and Specialty and Healthcare Services segments reflects the impact of investing the benefit of a lower tax rate from the 2017 Tax Reform Law into the establishment of an annual incentive compensation program for a broader range of employees, together with additional investments in the communities of our members, technology and our integrated care delivery model to drive more affordable healthcare and better clinical outcomes.
    - Our year-over-year pretax comparisons were also favorably impacted by strong Medicare Advantage membership growth and operating efficiencies from productivity initiatives implemented in 2017. These increases were partially offset by enhanced 2018 Medicare Advantage benefits resulting from investing the better than expected 2017 individual Medicare Advantage pretax earnings, coupled with the return of the health insurance industry fee, and a more severe flu season in 2018.
- Year-over-year comparisons of diluted earnings per common share were also favorably impacted by a lower number of shares used to compute earnings per common share from share repurchases and the impact of a lower tax rate for the year ended December 31, 2018.The 2017 Tax Reform Law coupled with the tax benefit

from the sale of KMG, partially offset by return of the nondeductible health insurance industry fee, drove the lower tax rate in 2018.

- We returned capital to our shareholders in the form of increased shareholder dividends and significant share repurchase. In 2018, we increased our per share dividend by 25% and repurchased shares worth approximately $1.1 billion, including the accelerated share repurchase agreement, or ASR, that we entered into in November 2018.
- The annual health insurance industry fee was suspended for calendar year 2017, but resumed in 2018. Operating costs associated with the health insurance industry fee attributable to 2018 were $1.04 billion paid in October 2018. This fee is not deductible for tax purposes, which increases our effective income tax rate. The one-year suspension in 2017 of the health insurance industry fee significantly reduced our operating costs and effective tax rate during 2017. The annual health insurance industry fee is also suspended for calendar year 2019, but under current law is scheduled to resume for calendar year 2020.

Retail Segment

- Individual and Group Medicare Advantage membership increased 259,600 members, or 7.9%, in 2018 to 3,561,800 members December 31, 2018.
- On January 30, 2019, after the stock market closed, the Centers for Medicare and Medicaid Services (CMS) issued its preliminary 2020 Medicare Advantage and Part D payment rates and proposed policy changes (collectively, the Advance Notice). CMS has invited public comment on the Advance Notice before publishing final rates on April 1, 2019 (the Final Notice). In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 1.59 percent increase in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee-for-service county rebasing/re-pricing since the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. Based on our preliminary analysis using the same factors CMS included in its estimate, the components of which are detailed on CMS' website, we anticipate the proposals in the Advance Notice would result in a change to our benchmark funding relatively in line with CMS' estimate. We will be drawing upon our program expertise to provide CMS formal commentary on the impact of the Advance Notice and the related impact upon Medicare beneficiaries' quality of care and service to our members through the Medicare Advantage program.
- On April 24, 2018, we received a Notice of Intent to be Awarded a Comprehensive Medicaid Contract under Florida's Statewide Managed Medicaid Program in all 11 regions, including the South Florida, Tampa, Jacksonville, and Orlando metro areas. The comprehensive program combines the traditional Medicaid, or TANF, and Long-Term Care programs. Phase-in under the new contract began December 2018 and was fully implemented February 1, 2019.
- In October 2018, CMS published its updated Star quality ratings for bonus year 2020. We received a 5-star rating on CMS' 5-star rating system for two MA contracts offered in Florida and Tennessee. In addition, we received a 4.5-star rating for two MA contracts offered in Florida, Illinois, Kentucky, Mississippi, North Carolina, and Oregon. We have 12 contracts rated 4-star or above and 3 million members in 4-star or above rated contracts to be offered in 2019, representing 84% of our MA membership as of July 2018. The achievement of a 5-star rating for two MA contracts in Florida and Tennessee provides us the ability to market for these contracts throughout the year, creating an opportunity for increased penetration in these important geographies. We cannot guarantee, however, our ability to maintain or improve our star ratings.

Group and Specialty Segment

- During 2018, we transitioned to the new, larger T2017 East Region contract increasing membership 2,846,800 or 92.4%.The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5-year contract set

to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Healthcare Services Segment

- We continued to invest in our Healthcare Services segment necessary to drive effective care delivery and clinical outcomes with our acquisitions of MCCI and FPG and our 40% investment in Kindred at Home.
- Medicare Advantage and dual demonstration program membership enrolled in a Humana chronic care management program was 716,000 at December 31, 2018, a decrease of 9.9% from 794,900 at December 31, 2017. These members may not be unique to each program since members have the ability to enroll in multiple programs. We have undergone an optimization process that ensures the appropriate level of member interaction with clinicians to drive quality outcomes, which has resulted in improved Retail segment operating results.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee levied on the insurance industry is $14.3 billion in 2018 and is not deductible for income tax purposes, which significantly increases our effective income tax rate. A one year suspension of the health insurance industry fee, as we experienced in 2017 and are experiencing in 2019, significantly impacts our trend in key operating metrics including our operating cost and medical expense ratios, as well as our effective tax rate. The annual health insurance industry fee is scheduled to resume for calendar year 2020 under current law.

As noted above, the Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual
open enrollment period. Although we previously participated in these exchanges by offering on-exchange individual
commercial medical plans, effective January 1, 2018, we have exited our Individual Commercial medical business.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016. Our case has been stayed by the Court, pending resolution of similar cases filed by other insurers.

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

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and

clinical care services, to our Retail and Group and Specialty segment customers and are described in Note 17 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2018 Form 10-K.

Comparison of Results of Operations for 2018 and 2017

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2018 and 2017:

Consolidated

			Change	
	2018	2017	Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 48,108	$ 44,626	$ 3,482	7.8 %
Group and Specialty	6,803	6,772	31	0.5 %
Individual Commercial	8	947	(939)	(99.2)%
Other Businesses	22	35	(13)	(37.1)%
Total premiums	54,941	52,380	2,561	4.9 %
Services:				
Retail	11	10	1	10.0 %
Group and Specialty	835	626	209	33.4 %
Healthcare Services	607	338	269	79.6 %
Other Businesses	4	8	(4)	(50.0)%
Total services	1,457	982	475	48.4 %
Investment income	514	405	109	26.9 %
Total revenues	56,912	53,767	3,145	5.8 %
Operating expenses:				
Benefits	45,882	43,496	2,386	5.5 %
Operating costs	7,525	6,567	958	14.6 %
Merger termination fee and related costs, net	—	(936)	936	(100.0)%
Depreciation and amortization	405	378	27	7.1 %
Total operating expenses	53,812	49,505	4,307	8.7 %
Income from operations	3,100	4,262	(1,162)	(27.3)%
Loss on sale of business	786	—	786	100.0 %
Interest expense	218	242	(24)	(9.9)%
Other expense, net	33	—	33	100.0 %
Income before income taxes and equity in net earnings	2,063	4,020	(1,957)	(48.7)%
Provision for income taxes	391	1,572	(1,181)	(75.1)%
Equity in net earnings of Kindred at Home	11	—	11	100.0 %
Net income	$ 1,683	$ 2,448	$ (765)	(31.3)%
Diluted earnings per common share	$ 12.16	$ 16.81	$ (4.65)	(27.7)%
Benefit ratio (a)	83.5%	83.0%		0.5 %
Operating cost ratio (b)	13.3%	12.3%		1.0 %
Effective tax rate	18.9%	39.1%		(20.2)%

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

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

Summary

Net income for 2018 was $1.7 billion, or $12.16 per diluted common share compared to $2.4 billion, or $16.81 per diluted common share, in 2017. This comparison was impacted by the loss on sale of KMG in 2018, the Merger Agreement break-up fee in 2017, the suspension of the health insurance industry fee for calendar year 2017, the exit out of the Individual Commercial business effective January 1, 2018, a lower tax rate due to the Tax Reform Law, charges associated with both voluntary and involuntary workforce reduction programs in 2017, and the estimated guaranty fund assessment expense to support the policyholders obligation of Penn Treaty in 2017. After consideration of these items, our earnings were favorably impacted by strong Medicare Advantage membership growth and significant operating efficiencies in 2018 driven by productivity initiatives implemented in 2017. These increases were partially offset by our offering of enhanced 2018 Medicare Advantage member benefits which resulted from the investment of the better than expected 2017 individual Medicare Advantage pretax earnings, coupled with the return of the health insurance industry fee and the more severe flu season during the first quarter of 2018.The comparison of diluted earnings per common share are also impacted by a lower number of shares from share repurchases.

Premiums Revenue

Consolidated premiums increased $2.6 billion, or 4.9%, from $52.4 billion for 2017 to $54.9 billion for 2018 primarily driven by higher Medicare Advantage revenues, partially offset by the impact of lower revenues from the exit of the Individual Commercial business.

Services Revenue

Consolidated services revenue increased $475 million, or 48.4%, from $982 million for 2017 to $1.5 billion for 2018, primarily due to an increase in services revenue in the Healthcare Services and Group and Specialty segments, as discussed in the detailed segment results discussion that follows.

Investment Income

Investment income was $514 million for 2018, increasing $109 million, or 26.9%, from 2017, primarily due to higher realized capital gains and higher interest rates in 2018, partially offset by lower average invested balances.

Benefits Expense

Consolidated benefits expense was $45.9 billion for 2018, an increase of $2.4 billion, or 5.5%, from 2017 reflecting an increase in the Retail and Group and Specialty segments benefits expense as discussed in the detailed segment results discussion that follows. These increases were partially offset by a decrease in the Individual Commercial segment benefits expense. As more fully described herein under the section entitled “Benefits Expense Recognition”, actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $503 million in 2018 and $483 million in 2017.

The consolidated benefit ratio for 2018 was 83.5%, an increase of 50 basis points from 2017 primarily due to the enhanced 2018 Medicare Advantage member benefits resulting from the investment of the better than expected 2017 individual Medicare Advantage pretax earnings and a more severe flu season in the first quarter of 2018. These items were partially offset by the positive impact from the reinstatement of the health insurance industry fee in 2018, which was contemplated in the pricing and benefit design of our products and higher favorable prior-period reserve development. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 90 basis points in both 2018 and 2017.

Operating Costs

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

Consolidated operating costs increased $958 million, or 14.6%, from 2017 to $7.5 billion in 2018 reflecting an increase in the Retail and Group and Specialty segments discussed in the detailed segment results discussion that follows. These increases were partially offset by a decrease in the Individual Commercial segment operating costs.

The consolidated operating cost ratio for 2018 was 13.3%, increasing 100 basis points from 12.3% in 2017 primarily due to the reinstatement of the health insurance industry fee in 2018, and long term sustainability investments made in 2018 as a result of the Tax Reform Law. Our long-term sustainability investments include the continuation of investments in our associate workforce, primarily the establishment of an annual incentive program for a broader range of employees, together with additional investments in the communities of our members, technology and our integrated care delivery model to drive more affordable healthcare and better clinical outcomes, and an increase in incentive compensation costs under the expanded program noted above. The ratio was further impacted by the growth in our military services business, which carries a higher operating ratio than our other products, due to the previously disclosed transition to the T2017 East Region contract effective January 1, 2018. These items were partially offset by the favorable impact of significant operating cost efficiencies in 2018 driven by productivity initiatives implemented in 2017, the impact of the charges recorded in 2017 associated with the voluntary and involuntary workforce reduction program, and the favorable year-over-year comparison of the impact of the guaranty fund assessment expense to support policyholder obligations of Penn Treaty in 2017, as well as the exit of the Individual Commercial business effective January 1, 2018, which carried a higher operating cost ratio than our other products. The nondeductible health insurance industry fee impacted the operating cost ratio by approximately 180 basis points in 2018.

Depreciation and Amortization

Depreciation and amortization in 2018 totaled $405 million compared to $378 million in 2017, an increase of 7.1%, primarily due to capital expenditures, the acquisitions of MCCI and FPG, and the write-off of a trade name value reflecting the re-branding of certain provider assets.

Interest Expense

Interest expense was $218 million for 2018 compared to $242 million for 2017, a decrease of $24 million, or 9.9%, primarily as a result of the early redemption of higher rate debt in December 2017.

Income Taxes

Our effective tax rate during 2018 was 18.9% compared to the effective tax rate of 39.1% in 2017. This decrease is primarily due to the Tax Reform Law and the tax benefit resulting from the sale of KMG, partially offset by the impact of the reinstatement of the non-deductible health insurance industry fee in 2018. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

	2018	2017	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	3,064,000	2,860,800	203,200	7.1 %
Group Medicare Advantage	497,800	441,400	56,400	12.8 %
Medicare stand-alone PDP	5,004,300	5,308,100	(303,800)	(5.7)%
Total Retail Medicare	8,566,100	8,610,300	(44,200)	(0.5)%
State-based Medicaid	341,100	360,100	(19,000)	(5.3)%
Medicare Supplement	254,300	235,900	18,400	7.8 %
Total Retail medical members	9,161,500	9,206,300	(44,800)	(0.5)%

	2018	2017	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 35,656	$ 32,720	$ 2,936	9.0 %
Group Medicare Advantage	6,103	5,155	948	18.4 %
Medicare stand-alone PDP	3,584	3,702	(118)	(3.2)%
Total Retail Medicare	45,343	41,577	3,766	9.1 %
State-based Medicaid	2,255	2,571	(316)	(12.3)%
Medicare Supplement	510	478	32	6.7 %
Total premiums	48,108	44,626	3,482	7.8 %
Services	11	10	1	10.0 %
Total premiums and services revenue	$ 48,119	$ 44,636	$ 3,483	7.8 %
Segment earnings	$ 1,733	$ 1,978	$ (245)	(12.4)%
Benefit ratio	85.1%	85.6%		(0.5)%
Operating cost ratio	11.1%	9.6%		1.5 %

Segment Earnings

- Retail segment earnings were $1.7 billion in 2018, a decrease of $245 million, or 12.4%, compared to 2017 reflecting a higher operating cost ratio in 2018, partially offset by a lower benefit ratio.

Enrollment

- Individual Medicare Advantage membership increased 203,200 members, or 7.1%, from December 31, 2017 to December 31, 2018 reflecting net membership additions associated with last year's Annual Election Period, or AEP, for Medicare beneficiaries. For full year 2019, we anticipate net membership growth in our individual Medicare Advantage offerings of 375,000 to 400,000.
- Group Medicare Advantage membership increased 56,400 members, or 12.8%, from December 31, 2017 to December 31, 2018 reflecting increased sales to our existing group accounts during last year's AEP for Medicare beneficiaries. For full year 2019, we anticipate net membership growth in our group Medicare Advantage offerings of approximately 30,000.

- Medicare stand-alone PDP membership decreased 303,800 members, or 5.7%, from December 31, 2017 to December 31, 2018 reflecting net declines during last year's AEP for Medicare beneficiaries. These declines primarily resulted from the previously disclosed loss of auto assigned members in Florida and South Carolina due to pricing over the CMS low income benchmark and continued membership declines in our Enhanced Plan. In addition, growth in our co-branded Walmart plan was significantly lower than historical levels due to the introduction of additional low-priced competitor offerings in many regions. For the full year 2019, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of 700,000 to 750,000.
- State-based Medicaid membership decreased 19,000 members, or 5.3%, from December 31, 2017 to December 31, 2018, primarily driven by our election not to participate in Illinois' Medicaid Integrated Care Program and the Virginia Long Term Support Services contract that replaced the state's previous stand-alone dual eligible demonstration program in December 2017. Year-over-year decline was also impacted by lower membership associated with our Florida Medicaid contract due to overall strengthening economic conditions, partially offset by the addition of members associated with the new Florida Managed Medical Assistance program from the contract phase-in for certain regions that began December 1, 2018.

Premiums revenue

- Retail segment premiums increased $3.5 billion, or 7.8%, from 2017 to 2018 primarily reflecting individual and group Medicare Advantage membership growth in last year's AEP as well as increased per-member premiums for certain of the segment's products, partially offset by declines in stand-alone PDP and state-based contracts revenues resulting from year-over-year membership declines discussed above. Average group and individual Medicare Advantage membership increased 7.6% in 2018. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per-member premiums. Items impacting average per-member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Benefits expense

- The Retail segment benefit ratio of 85.1% for 2018 decreased 50 basis points from 2017 primarily due to the reinstatement of the non-deductible health insurance industry fee in 2018 which was contemplated in the pricing and benefit design of our products, partially offset by the unfavorable impact from enhanced 2018 Medicare Advantage member benefits resulting from the investment of the better than expected 2017 individual Medicare Advantage pretax earnings. 2018 was also impacted by a more severe flu season.
- The Retail segment’s benefits expense for 2018 included the beneficial effect of $398 million in favorable prior-year medical claims reserve development versus $386 million in 2017. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 80 basis points in 2018 versus approximately 90 basis points in 2017.

Operating costs

- The Retail segment operating cost ratio of 11.1% for 2018 increased 150 basis points from 2017 primarily due to the reinstatement of the health insurance industry fee in 2018 and increase in incentive compensation costs under the expanded program, resulting from the strategic investments made in 2018 as a result of the Tax Reform Law. These items were partially offset by significant operating cost efficiencies in 2018 driven by productivity initiatives implemented in 2017.
- The non-deductible health insurance industry fee increased the operating cost ratio by approximately 190 basis points in 2018.

Group and Specialty Segment

	2018	2017	Change Members	Change Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,004,700	1,097,700	(93,000)	(8.5)%
ASO	481,900	458,700	23,200	5.1 %
Military services	5,928,600	3,081,800	2,846,800	92.4 %
Total group medical members	7,415,200	4,638,200	2,777,000	59.9 %
Specialty membership (a)	6,072,300	6,986,000	(913,700)	(13.1)%

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

	2018	2017	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,444	$ 5,462	$ (18)	(0.3)%
Specialty	1,359	1,310	49	3.7 %
Total premiums	6,803	6,772	31	0.5 %
Services	835	626	209	33.4 %
Total premiums and services revenue	$ 7,638	$ 7,398	$ 240	3.2 %
Segment earnings	$ 361	$ 412	$ (51)	(12.4)%
Benefit ratio	79.7%	79.2%		0.5 %
Operating cost ratio	23.6%	21.4%		2.2 %

Segment Earnings

- Group and Specialty segment earnings were $361 million in 2018, a decrease of $51 million, or 12.4%, from $412 million in 2017 primarily reflecting higher benefit and operating cost ratios in 2018, partially offset by a favorable year-over-year earnings comparison for our group ASO commercial medical business.

Enrollment

- Fully-insured commercial group medical membership decreased 93,000 members, or 8.5% from December 31, 2017 primarily reflecting lower membership in small group accounts due in part to more small group accounts selecting level-funded ASO products in 2018. The portion of group fully-insured commercial medical membership in small group accounts was approximately 61% at December 31, 2018 and 64% at December 31, 2017.
- Group ASO commercial medical membership increased 23,200 members, or 5.1%, from December 31, 2017 to December 31, 2018 reflecting more small group accounts selecting level-funded ASO products in 2018, partially offset by the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.
- Specialty membership decreased 913,700 members, or 13.1%, from December 31, 2017 to December 31, 2018 primarily resulted from the exit of our voluntary benefits and financial protection lines of business in connection

with the sale of KMG, as well as the loss of some large group accounts offering stand-alone dental and vision products. These decreases were partially offset by an increase in individual dental and vision membership.

Premiums revenue

- Group and Specialty segment premiums increased $31 million, or 0.5%, from 2017 to 2018 primarily due to higher stop-loss premiums related to our level funded ASO accounts resulting from membership growth in this product, and higher per-member premiums across the commercial fully-insured business, partially offset by the exit of our voluntary benefits and financial protection lines of business in connection with the sale of KMG, as well as declines in average group fully-insured commercial medical membership.

Services revenue

- Group and Specialty segment services revenue increased $209 million, or 33.4%, from 2017 to 2018 as a result of the transition to the TRICARE T2017 East Region contract on January 1, 2018.

Benefits expense

- The Group and Specialty segment benefit ratio increased 50 basis points from 79.2% in 2017 to 79.7% in 2018 primarily due to retroactive contractual rate adjustments, membership mix, including the continued migration of healthier groups to level funded ASO products in 2018, and the impact of the exit of our voluntary benefits and financial protection lines of business in connection with the sale of KMG, which carried a very low benefit ratio. These factors were partially offset by the reinstatement of the health insurance industry fee in 2018 which was contemplated in the pricing of our products, and higher favorable prior-period reserve development.

- The Group and Specialty segment's benefits expense included the beneficial effect of $46 million in favorable prior-year medical claims reserve development in 2018 versus $40 million in 2017. This favorable prior-year medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2018 versus approximately 60 basis points in 2017.

Operating costs

- The Group and Specialty segment operating cost ratio of 23.6% for 2018 increased 220 basis points from 21.4% for 2017. These increases primarily were due to the reinstatement of the health insurance industry fee in 2018, growth in our military services business, which carries a higher operating cost ratio than other products within the segment, as a result of the transition to the TRICARE T2017 East Region contract, an increase in incentive compensation costs under the expanded program resulting from the strategic investments made in 2018 as a result of the Tax Reform Law. These items were partially offset by significant operating cost efficiencies driven by productivity initiatives implemented in 2017, and the impact of the exit of our voluntary benefits and financial protection lines of business in connection with the sale of KMG. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2018.

Healthcare Services Segment

	2018	2017	Change	
			Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$ 176	$ 181	$ (5)	(2.8)%
Pharmacy solutions	203	80	123	153.8 %
Provider services	228	77	151	196.1 %
Total services revenues	607	338	269	79.6 %
Intersegment revenues:				
Pharmacy solutions	20,514	20,881	(367)	(1.8)%
Provider services	1,994	1,593	401	25.2 %
Clinical care services	662	1,111	(449)	(40.4)%
Total intersegment revenues	23,170	23,585	(415)	(1.8)%
Total services and intersegment revenues	$ 23,777	$ 23,923	$ (146)	(0.6)%
Segment earnings	$ 754	$ 967	$ (213)	(22.0)%
Operating cost ratio	96.3%	95.5%		0.8 %

Segment Earnings

- Healthcare Services segment earnings were $754 million in 2018, a decrease of $213 million, or 22.0%, from 2017 primarily due to the impact of the optimization process associated with our chronic care management programs and investments made in 2018 as a result of the Tax Reform Law, partially offset by the impact of Kindred at Home.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 440 million in 2018, up 2% versus scripts of approximately 433 million in 2017. The increase primarily reflects growth associated with higher Individual Advantage Medicare membership, partially offset by the decline in stand-alone PDP and Individual Commercial membership.

Services revenue

- Services revenue increased $269 million, or 79.6%, from 2017 to $607 million for 2018 primarily due to service revenue growth from our provider services and pharmacy solutions business.

Intersegment revenues

- Intersegment revenues decreased $415 million, or 1.8%, from 2017 to $23.2 billion for 2018 primarily due to a decline in pharmacy solutions revenue due to lower stand-alone PDP membership, the loss of intersegment revenues associated with our exit from the Individual commercial business, the result of improving the effectiveness of our chronic care management programs, and the impact to our provider services business of the lower Medicare rates year-over-year in geographies where our provider assets are primarily located. These declines were partially offset by Medicare Advantage membership growth as well as higher intersegment revenues associated with our provider services business reflecting our acquisition of MCCI.

Operating costs

- The Healthcare Services segment operating cost ratio of 96.3% for 2018 increased from 95.5% for 2017 primarily due to an increase in incentive compensation costs under the expanded program resulting from the strategic investments made in 2018 as a result of the Tax Reform Law and the lag in operating cost reduction associated with improving the effectiveness of our chronic care management programs as compared to the timing of reduction in revenue. These items were partially offset by significant operating cost efficiencies in 2018 driven by productivity initiatives implemented in 2017.

Individual Commercial Segment

- In 2018, our Individual Commercial segment pretax income was $74 million, a decrease of $119 million, from a pretax income of $193 million in 2017 primarily due to the impact of favorable prior-period reserve development from the run-out of this business. We exited this business effective January 1, 2018.

Other Businesses

As previously disclosed, in the third quarter of 2018, we completed the sale of our wholly-owned subsidiary KMG, as discussed further in Note 3 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2018 Form 10-K.

Comparison of Results of Operations for 2017 and 2016

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

Consolidated

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

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

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

Summary

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

Premiums Revenue

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

Services Revenue

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

Investment Income

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

Benefits Expense

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

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

Operating Costs

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

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

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

Depreciation and Amortization

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

Interest Expense

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

Income Taxes

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

Retail Segment

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

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

Segment Earnings

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

Enrollment

- Individual Medicare Advantage membership increased 23,200 members, or 0.8%, from December 31, 2016 to December 31, 2017 reflecting net membership additions for Medicare beneficiaries including the effect of planned market and product exits in 2017. We decided certain markets and/or products were not meeting long term strategic and financial objectives. Additionally, membership growth was muted due to competitive actions including the uncertainty associated with the then-pending Merger transaction during last year's AEP.

- Group Medicare Advantage membership increased 86,000 members, or 24.2%, from December 31, 2016 to December 31, 2017 reflecting the addition of a large account in January 2017.

- Medicare stand-alone PDP membership increased 356,700 members, or 7.2%, from December 31, 2016 to December 31, 2017 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2017 plan year.
- State-based Medicaid membership decreased 28,000 members, or 7.2%, from December 31, 2016 to December 31, 2017 primarily driven by lower membership associated with our Florida contracts resulting from network realignments.

Premiums revenue

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

Benefits expense

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

Operating costs

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

Group and Specialty Segment

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

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

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

Segment Earnings

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

Enrollment

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

Premiums revenue

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

Services revenue

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

Benefits expense

- The Group and Specialty segment benefit ratio increased 100 basis points from 78.2% in 2016 to 79.2% in 2017 primarily due to the impact of the temporary suspension of the health insurance industry fee for calendar year 2017 which was contemplated in the pricing of our products. The increase was further impacted by an increased proportion of small group members transitioning to community rated plans that carry a higher benefit ratio. These increases were partially offset by lower utilization for the fully-insured commercial medical business in 2017, primarily associated with the large group business.

- The Group and Specialty segment's benefits expense included the beneficial effect of $40 million in favorable prior-year medical claims reserve development in 2017 versus $46 million in 2016. This favorable prior-year medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 60 basis points in 2017 versus approximately 70 basis points in 2016.

Operating costs

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

Healthcare Services Segment

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

Segment Earnings

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

Script Volume

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

Services revenue

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

Intersegment revenues

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

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

Operating costs

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

Individual Commercial Segment

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

Other Businesses

As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2018 Form 10-K.

Liquidity

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

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2018 Form 10-K.

Cash and cash equivalents decreased to $2.3 billion at December 31, 2018 from $4.0 billion at December 31, 2017. The change in cash and cash equivalents for the years ended December 31, 2018, 2017 and 2016 is summarized as follows:

	2018	2017	2016
		(in millions)	
Net cash provided by operating activities	$ 2,173	$ 4,051	$ 1,936
Net cash used in investing activities	(3,087)	(2,941)	(1,362)
Net cash (used in) provided by financing activities	(785)	(945)	732
(Decrease) increase in cash and cash equivalents	$ (1,699)	$ 165	$ 1,306

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in the timing of working capital items, earnings, and enrollment activity as discussed below. The decrease in operating cash flows in 2018 primarily was due to the receipt of the merger termination fee in 2017, net of related expenses and taxes paid, funding the reinsurance of certain voluntary benefit and financial protection products to a third party in connection with the sale of KMG in 2018, and the timing of working capital items.

The increase in operating cash flows in 2017 primarily was due to the receipt of the merger termination fee, net of related expenses and taxes paid, higher earnings and the timing of working capital items.

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

The detail of benefits payable was as follows at December 31, 2018, 2017 and 2016:

				Change		
	2018	2017	2016	2018	2017	2016
			(in millions)			
IBNR (1)	$ 3,361	$ 3,154	$ 3,422	$ 207	$ (268)	$ (308)
Reported claims in process (2)	617	614	654	3	(40)	54
Premium deficiency reserve (3)	—	—	—	—	—	(176)
Other benefits payable (4)	884	900	487	(16)	413	17
Total benefits payable	$ 4,862	$ 4,668	$ 4,563	194	105	(413)
Payables from disposition				58	—	—
Change in benefits payable per cash flow statement resulting in cash from operations				$ 252	$ 105	$ (413)

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

The increase in benefits payable in 2018 was primarily due to an increase in IBNR, mainly as a result of Medicare Advantage membership growth. The increase in benefits payable from 2016 to 2017 primarily was due to an increase in the amounts owed to providers under the capitated and risk sharing arrangements. This was partially offset by a decrease in IBNR primarily driven by declines in individual commercial medical membership in the 2017 period, partially offset by an increase in group Medicare Advantage membership. Benefits payable decreased in 2016 primarily due to a decrease in IBNR, as well as the application of 2016 results to the premium deficiency reserve liability recognized in 2015 associated with our individual commercial medical products compliant with the Health Care Reform Law for the 2016 coverage year.

IBNR decreased during 2017 and 2016 primarily due to declines in individual and fully-insured group commercial membership. The decrease in IBNR during 2016 was also impacted by declines in group Medicare Advantage membership.

The detail of total net receivables was as follows at December 31, 2018, 2017 and 2016:

				Change		
	2018	2017	2016	2018	2017	2016
			(in millions)			
Medicare	$ 836	$ 511	$ 787	$ 325	$ (276)	$ 101
Commercial and other	135	273	579	(138)	(306)	39
Military services	123	166	32	(43)	134	(29)
Allowance for doubtful accounts	(79)	(96)	(118)	17	22	(3)
Total net receivables	$ 1,015	$ 854	$ 1,280	161	(426)	108
Reconciliation to cash flow statement:						
Provision for doubtful accounts				36	20	39
Change in receivables disposed from sale of business				3	—	11
Change in receivables per cash flow statement resulting in cash from operations				$ 200	$ (406)	$ 158

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

The decrease in commercial and other receivables in 2018 as compared to 2017, as well as the decrease in 2017 as compared to 2016, was due primarily to a decrease in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law. This decrease corresponds with our exit from the Individual Commercial business.

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

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. The effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform law, also known as the 3R's, has impacted our operating cash flows over the last three years, but more significantly in 2017 and 2016 as the temporary risk corridor and reinsurance program provisions phased out in 2016. The timing of payments and receipts associated with these provisions impacted our operating cash flows as we built receivables for each coverage year that were expected to be collected in subsequent coverage years. Net collections under the 3Rs associated with prior coverage years were $8 million in 2018, $440 million in 2017 and $383 million in 2016. The annual health insurance industry fee was suspended for the calendar year 2017, but resumed in calendar year 2018. The annual health insurance industry fee was also suspended for the calendar year 2019 and, under current law, is scheduled to resume in calendar year 2020. We paid the federal government annual health insurance industry fees of $1.04 billion in 2018 and $916 million in 2016.

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

Cash Flow from Investing Activities

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care

coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $612 million in 2018, $524 million in 2017, and $527 million in 2016.

In 2018, we completed the sale of our wholly-owned subsidiary KMG to CGIC. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. Total cash and cash equivalents, including parent company funding, disposed at the time of sale, was $805 million. See Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data

During 2018 we paid cash consideration of approximately $1.1 billion to acquire a 40% minority interest in Kindred at Home, $169 million to acquire the remaining interest in MCCI, and $185 million to acquire all of FPG, as discussed in Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $221 million, $2.4 billion, and $828 million during 2018, 2017 and 2016 respectively.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Claims payments were $653 million higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk during 2018. Receipts from CMS associated with Medicare Part D claims subsidies for which we do not assume risk were $1.9 billion higher than claims payments during 2017 and were $1.1 billion higher than claims payments during 2016. Our net payable for CMS subsidies and brand name prescription drug discounts was $331 million at December 31, 2018 compared to a net payable of $1.0 billion at December 31, 2017.

Under our administrative services only TRICARE contract, reimbursements from the federal government exceeded health care cost payments for which we do not assume risk by $38 million in 2018 and by $11 million in 2017. Health care cost payments for which we do not assume risk exceeded reimbursements from the federal government by $25 million in 2016.

Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were $25 million in 2018. There were no reimbursements from HHS in 2018. Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were higher than reimbursements from HHS by $44 million in 2017 and by $28 million in 2016.

We repurchased common shares for $1.09 billion in 2018 and $3.37 billion in 2017 under share repurchase plans authorized by the Board of Directors and in connection with employee stock plans. We did not repurchase shares in 2016 due to restrictions under the Merger Agreement.

As discussed further below, we paid dividends to stockholders of $265 million in 2018, $220 million in 2017, and $177 million in 2016.

We entered into a commercial paper program in October 2014. Net proceeds from the issuance of commercial paper were $485 million in 2018 and the maximum principal amount outstanding at any one time during 2018 was $923 million. Net repayments of commercial paper were $153 million in 2017 and the maximum principal amount outstanding at any one time during 2017 was $500 million. Net repayments of commercial paper were $2 million in 2016 and the maximum principal amount outstanding at any one time during 2016 was $475 million.

In December 2017, we issued $400 million of 2.50% senior notes due December 15, 2020 and $400 million of 2.90% senior notes due December 15, 2022. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of December 31, 2017, were $794 million. We used the net proceeds, together with

available cash, to fund the redemption of our $300 million aggregate principal amount of 6.30% senior notes maturing in August 2018 and our $500 million aggregate principal amount of 7.20% senior notes maturing in June 2018 at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $829 million.

The remainder of the cash used in or provided by financing activities in 2018, 2017, and 2016 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

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

Stock Repurchases

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

Debt

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

Liquidity Requirements

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

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2018 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $250 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $1 million, up to a maximum 100 basis points, or annual interest expense by $3 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company decreased to $578 million at December 31, 2018 from $688 million at December 31, 2017. This decrease primarily reflects acquisitions, common stock repurchases, insurance subsidiaries' capital contributions and capital expenditures, partially offset by insurance subsidiaries dividends, non-insurance subsidiaries' profits and net proceeds from debt issuance. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated insurance subsidiaries paid dividends to the parent of $2.3 billion in 2018, $1.4 billion in 2017, and $0.8 billion in 2016. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. The amount of ordinary dividends that may be paid to our parent company in 2019 is approximately $1 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory

capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Regulatory Requirements

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

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2018 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
			(in millions)		
Debt	$ 6,097	$ 1,697	$ 400	$ 1,000	$ 3,000
Interest (1)	8,955	1,926	1,161	914	4,954
Operating leases (2)	519	147	210	112	50
Purchase obligations (3)	736	240	337	159	—
Future policy benefits payable and other long-term liabilities (4)	724	53	444	68	159
Total	$ 17,031	$ 4,063	$ 2,552	$ 2,253	$ 8,163

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

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. See also Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

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

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

Off-Balance Sheet Arrangements

As of December 31, 2018, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

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

Government Contracts

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

Critical Accounting Policies and Estimates

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

Benefits Expense Recognition

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

	December 31, 2018	Percentage of Total	December 31, 2017	Percentage of Total
	(dollars in millions)			
IBNR	$ 3,361	69.1%	$ 3,154	67.6%
Reported claims in process	617	12.7%	614	13.1%
Other benefits payable	884	18.2%	900	19.3%
Total benefits payable	$ 4,862	100.0%	$ 4,668	100.0%

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

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderately adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2018 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
0.70%	$(258)	(3.00)%	$(224)
0.60%	$(222)	(2.75)%	$(206)
0.50%	$(185)	(2.50)%	$(187)
0.40%	$(148)	(2.25)%	$(168)
0.30%	$(111)	(2.00)%	$(150)
0.20%	$(74)	(1.75)%	$(131)
0.10%	$(37)	(1.50)%	$(112)

(a) Reflects estimated potential changes in benefits payable at December 31, 2018 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2018 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

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

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail, Group and Specialty, and Individual Commercial segment tables including information about incurred and paid claims development as of December 31, 2018, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2018	2017	2016
	(in millions)		
Balances at January 1	$ 4,668	$ 4,563	$ 4,976
Less: Premium deficiency reserve	—	—	(176)
Less: Reinsurance recoverables	(70)	(76)	(85)
Balances at January 1, net	4,598	4,487	4,715
Incurred related to:			
Current year	46,385	44,001	45,318
Prior years	(503)	(483)	(582)
Total incurred	45,882	43,518	44,736
Paid related to:			
Current year	(41,736)	(39,496)	(40,852)
Prior years	(3,977)	(3,911)	(4,112)
Total paid	(45,713)	(43,407)	(44,964)
Reinsurance recoverable	95	70	76
Balances at December 31	$ 4,862	$ 4,668	$ 4,563

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

	Favorable Development by Changes in Key Assumptions					
	2018		2017		2016	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (229)	(3.3)%	$ (279)	(2.7)%	$ (316)	(2.9)%
Completion factors	(274)	(0.8)%	(204)	(0.7)%	(266)	(0.9)%
Total	$ (503)		$ (483)		$ (582)	

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $503 million in 2018, $483 million in 2017, and $582 million in 2016. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2018, 2017, and 2016.

	Favorable Medical Claims Reserve Development			Change	
	2018	2017	2016	2018	2017
	(in millions)				
Retail Segment	$ (398)	$ (386)	$ (429)	$ (12)	$ 43
Group and Specialty Segment	(46)	(40)	(46)	(6)	6
Individual Commercial Segment	(57)	(56)	(106)	(1)	50
Other Businesses	(2)	(1)	(1)	(1)	—
Total	$ (503)	$ (483)	$ (582)	$ (20)	$ 99

The favorable medical claims reserve development for 2018, 2017, and 2016 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2018 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Premium deficiency reserve for short-duration policies	$ —	$ —	$ (176)
Military services	—	—	8
Future policy benefits	—	(22)	439
Total	$ —	$ (22)	$ 271

In 2016, we increased our existing premium deficiency reserve, initially recorded in 2015, for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies, which were sold in 2018, as more fully described below and in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Revenue Recognition

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

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and recognized ratably during the year with adjustments each period to reflect changes in the ultimate premium.

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

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those

enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare," and in Item 1A. - Risk Factors.

Investment Securities

Investment securities totaled $10.4 billion, or 41% of total assets at December 31, 2018, and $12.3 billion, or 45% of total assets at December 31, 2017. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2018 and 2017. The fair value of debt securities were as follows at December 31, 2018 and 2017:

	12/31/2018	Percentage of Total	12/31/2017	Percentage of Total
			(dollars in millions)	
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 417	4.0%	$ 531	4.3%
Mortgage-backed securities	2,544	24.4%	1,610	13.1%
Tax-exempt municipal securities	2,771	26.5%	3,889	31.6%
Mortgage-backed securities:				
Residential	55	0.5%	26	0.2%
Commercial	523	5.0%	456	3.7%
Asset-backed securities	985	9.4%	408	3.3%
Corporate debt securities	3,142	30.2%	5,382	43.8%
Total debt securities	$ 10,437	100.0%	$ 12,302	100.0%

Approximately 97% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2018. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $118 million at December 31, 2018 and $222 million at December 31, 2017. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.4 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for $1.3 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 9%.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2018:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2018						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 179	$ (1)	$ 153	$ (2)	$ 332	$ (3)
Mortgage-backed securities	956	(16)	1,019	(38)	1,975	(54)
Tax-exempt municipal securities	809	(9)	1,648	(28)	2,457	(37)
Mortgage-backed securities:						
Residential	—	—	15	—	15	—
Commercial	372	(8)	133	(6)	505	(14)
Asset-backed securities	824	(7)	40	—	864	(7)
Corporate debt securities	1,434	(35)	1,439	(63)	2,873	(98)
Total debt securities	$ 4,574	$ (76)	$ 4,447	$ (137)	$ 9,021	$ (213)

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

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

All issuers of securities we own that were trading at an unrealized loss at December 31, 2018 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2018, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2018. There were no material other-than-temporary impairments in 2018, 2017, or 2016.

Goodwill and Long-lived Assets

At December 31, 2018, goodwill and other long-lived assets represented 23% of total assets and 58% of total stockholders' equity, compared to 19% and 52%, respectively, at December 31, 2017 with the increase due to our 2018 acquisitions.

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

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in Government rates, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our clinical and provider reporting units in our Healthcare Services segment. The margin on the clinical reporting unit would decline to less than 10% after factoring in a 100 basis point increase in the discount rate. The provider reporting unit, while not falling beneath this threshold, was closer than any of our other reporting units. The clinical and provider reporting units account for $524 million and $730 million, respectively, of goodwill.

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

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. In the past we have, and in the future we may enter into interest rate swap agreements depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $2.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2018 or December 31, 2017.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA at December 31, 2018. Our net unrealized position decreased $402 million from a net unrealized gain position of $198 million at December 31, 2017 to a net unrealized loss position of $204 million at December 31, 2018. At December 31, 2018, we had gross unrealized losses of $213 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. There were no material other-than-temporary impairments during 2018. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 2.9 years as of December 31, 2018 and 4.1 years as of December 31, 2017. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $365 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2018 and 2017. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have not exceeded 300 basis points, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points twice, and have changed by less than 100 basis points eight times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2018						
Investment income (a)	$ (154)	$ (114)	$ (57)	$ 58	$ 116	$ 175
Interest expense (b)	31	20	10	(10)	(20)	(31)
Pretax	$ (123)	$ (94)	$ (47)	$ 48	$ 96	$ 144
As of December 31, 2017						
Investment income (a)	$ (87)	$ (83)	$ (67)	$ 67	$ 134	$ 202
Interest expense (b)	2	2	2	(2)	(3)	(5)
Pretax	$ (85)	$ (81)	$ (65)	$ 65	$ 131	$ 197

(a) As of December 31, 2018 and 2017, some of our investments had interest rates below 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2018 or December 31, 2017. There was $645 million and $150 million outstanding under our commercial paper program at December 31, 2018 and 2017, respectively. As of December 31, 2017, our interest rate under our commercial paper program was less than 2% so the assumed hypothetical change in pretax earnings does not reflect the full 2% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2018	2017
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,343	$ 4,042
Investment securities	10,026	9,557
Receivables, less allowance for doubtful accounts of $79 in 2018 and $96 in 2017	1,015	854
Other current assets	3,564	2,949
Total current assets	16,948	17,402
Property and equipment, net	1,735	1,584
Long-term investment securities	411	2,745
Equity method investment in Kindred at Home	1,047	—
Goodwill	3,897	3,281
Other long-term assets	1,375	2,166
Total assets	$ 25,413	$ 27,178
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 4,862	$ 4,668
Trade accounts payable and accrued expenses	3,067	4,069
Book overdraft	171	141
Unearned revenues	283	378
Short-term debt	1,694	150
Total current liabilities	10,077	9,406
Long-term debt	4,375	4,770
Future policy benefits payable	219	2,923
Other long-term liabilities	581	237
Total liabilities	15,252	17,336
Commitments and contingencies (Note 16)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,594,841 shares issued at December 31, 2018 and 198,572,458 shares issued at December 31, 2017	33	33
Capital in excess of par value	2,535	2,445
Retained earnings	15,072	13,670
Accumulated other comprehensive (loss) income	(159)	19
Treasury stock, at cost, 63,028,169 shares at December 31, 2018 and 60,893,762 shares at December 31, 2017	(7,320)	(6,325)
Total stockholders' equity	10,161	9,842
Total liabilities and stockholders' equity	$ 25,413	$ 27,178

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

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2018	**2017**	**2016**
	(in millions, except per share results)		
Revenues:			
Premiums	$ 54,941	$ 52,380	$ 53,021
Services	1,457	982	969
Investment income	514	405	389
Total revenues	56,912	53,767	54,379
Operating expenses:			
Benefits	45,882	43,496	45,007
Operating costs	7,525	6,567	7,173
Merger termination fee and related costs, net	—	(936)	104
Depreciation and amortization	405	378	354
Total operating expenses	53,812	49,505	52,638
Income from operations	3,100	4,262	1,741
Loss on sale of business	786	—	—
Interest expense	218	242	189
Other expense, net	33	—	—
Income before income taxes and equity in net earnings	2,063	4,020	1,552
Provision for income taxes	391	1,572	938
Equity in net earnings of Kindred at Home	11	—	—
Net income	$ 1,683	$ 2,448	$ 614
Basic earnings per common share	$ 12.24	$ 16.94	$ 4.11
Diluted earnings per common share	$ 12.16	$ 16.81	$ 4.07

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

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2018	2017	2016
	(in millions)		
Net income	$ 1,683	$ 2,448	$ 614
Other comprehensive income (loss):			
Change in gross unrealized investment losses/gains	(189)	149	(101)
Effect of income taxes	51	(55)	38
Total change in unrealized investment gains/losses, net of tax	(138)	94	(63)
Reclassification adjustment for net realized gains included in investment income	(53)	(14)	(96)
Effect of income taxes	17	5	35
Total reclassification adjustment, net of tax	(36)	(9)	(61)
Other comprehensive (loss) income, net of tax	(174)	85	(124)
Comprehensive income attributable to our equity method investment in Kindred at Home	(4)	—	—
Comprehensive income	$ 1,505	$ 2,533	$ 490

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

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2016	198,372	$ 33	$ 2,530	$ 11,017	$ 58	$ (3,292)	$ 10,346
Net income				614			614
Other comprehensive loss					(124)		(124)
Common stock repurchases			—			(104)	(104)
Dividends and dividend equivalents			—	(177)			(177)
Stock-based compensation			115				115
Restricted stock unit vesting	13	—	(98)			98	—
Stock option exercises	110	—	13				13
Stock option and restricted stock tax benefit			2				2
Balances, December 31, 2016	198,495	33	2,562	11,454	(66)	(3,298)	10,685
Net income				2,448			2,448
Other comprehensive income					85		85
Common stock repurchases			(200)			(3,165)	(3,365)
Dividends and dividend equivalents			—	(232)			(232)
Stock-based compensation			157				157
Restricted stock unit vesting	—	—	(138)			138	—
Stock option exercises	77	—	64				64
Balances, December 31, 2017	198,572	33	2,445	13,670	19	(6,325)	9,842
Net income				1,683			1,683
Other comprehensive loss				(4)	(178)		(182)
Common stock repurchases			50			(1,140)	(1,090)
Dividends and dividend equivalents			—	(277)			(277)
Stock-based compensation			137				137
Restricted stock unit vesting	—	—	(145)			145	—
Stock option exercises	23	—	48				48
Balances, December 31, 2018	198,595	$ 33	$ 2,535	$ 15,072	$ (159)	$ (7,320)	$ 10,161

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

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW

	For the year ended December 31,		
	2018	**2017**	**2016**
		(in millions)	
Cash flows from operating activities			
Net income	$ 1,683	$ 2,448	$ 614
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss on sale of business	786	—	—
Net realized capital gains	(90)	(14)	(96)
Equity in net earnings of Kindred at Home	(11)	—	—
Stock-based compensation	137	157	115
Depreciation	444	410	388
Amortization	90	75	77
Provision (benefit) for deferred income taxes	194	132	(71)
Provision for doubtful accounts	36	20	39
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(200)	406	(158)
Other assets	(484)	(582)	426
Benefits payable	252	105	(413)
Other liabilities	(676)	641	937
Unearned revenues	(95)	98	(84)
Other	107	155	162
Net cash provided by operating activities	2,173	4,051	1,936
Cash flows from investing activities			
Acquisitions, net of cash acquired	(354)	(31)	(7)
Acquisition, equity method investment in Kindred at Home	(1,095)	—	—
Cash transferred in sale of business	(805)	—	—
Purchases of property and equipment	(612)	(524)	(527)
Purchases of investment securities	(4,687)	(6,265)	(6,566)
Maturities of investment securities	972	1,111	1,426
Proceeds from sales of investment securities	3,494	2,768	4,312
Net cash used in investing activities	(3,087)	(2,941)	(1,362)
Cash flows from financing activities			
(Withdrawals) receipts from contract deposits, net	(640)	1,823	1,093
Proceeds from issuance of senior notes, net	—	1,779	—
Proceeds from issuance (repayments) of commercial paper, net	485	(153)	(2)
Proceeds from term loan	1,000	—	—
Repayment of term loan	(350)	—	—
Repayment of long-term debt	—	(800)	—
Common stock repurchases	(1,090)	(3,365)	(104)
Dividends paid	(265)	(220)	(177)
Change in book overdraft	30	(71)	(89)
Proceeds from stock option exercises and other, net	45	62	11
Net cash (used in) provided by financing activities	(785)	(945)	732
(Decrease) increase in cash and cash equivalents	(1,699)	165	1,306
Cash and cash equivalents at beginning of year	4,042	3,877	2,571
Cash and cash equivalents at end of year	$ 2,343	$ 4,042	$ 3,877

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW—(Continued)

	For the year ended December 31,		
	2018	**2017**	**2016**
Supplemental cash flow disclosures:		**(in millions)**	
Interest payments	$ 195	$ 216	$ 185
Income tax payments, net	$ 631	$ 1,498	$ 916
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 392	$ 31	$ 7
Less: Fair value of liabilities assumed	(38)	—	—
Cash paid for acquired businesses, net of cash acquired	$ 354	$ 31	$ 7

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

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 81% of our total premiums and services revenue from contracts with the federal government in 2018, including 15% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

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

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

Workforce Optimization

During the third quarter of 2017, we initiated a voluntary early retirement program and an involuntary workforce reduction program. These programs impacted approximately 3,600 associates, or 7.8% of our workforce. As a result, in 2017 we recorded charges of $148 million, or $0.64 per diluted common share. At December 31, 2017, $140 million was classified as a current liability, included in our consolidated balance sheet in the trade accounts payable and accrued expenses line. Payments under these programs are being made upon termination during the early retirement or severance pay period. The remaining workforce optimization liability at December 31, 2018, was $12 million and is expected to be paid in 2019.

Aetna Merger

On February 16, 2017, under the terms of the Agreement and Plan of Merger, or Merger Agreement, with Aetna Inc., and certain wholly owned subsidiaries of Aetna Inc., which we collectively refer to as Aetna, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned "Merger termination fee and related costs, net."

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

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges. Operating results for our individual commercial medical business compliant with the Health Care Reform Law were challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. As a result of these and other factors, we exited our individual commercial medical business effective January 1, 2018.

The annual premium-based fee on health insurers is not deductible for tax purposes. We estimate a liability for the health insurance industry fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurance industry fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurance industry fee in September or October of each year. The Consolidated Appropriations Act enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurance industry fee. In 2018, we paid the federal government $1.04 billion for the annual health insurance industry fee attributed to calendar year 2018. In 2016, we paid the federal government $916 million for the annual health insurance industry fee attributed to calendar year 2016. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurance industry fee, but under current law, the fee is scheduled to resume in calendar year 2020.

Cash and Cash Equivalents

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

Investment Securities

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

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

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

credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase.

Receivables and Revenue Recognition

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

Premiums Revenue

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium. Receivables or payables are classified as current or long-term in our consolidated balance sheet based on the timing of the expected settlement.

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

Medicare Part D

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

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

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent

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

funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2018, subsidy and discount payments of $10.3 billion exceeded reimbursements of $9.6 billion by $0.7 billion. For 2017, subsidy and discount reimbursements of $12.1 billion exceeded payments of $10.2 billion by $1.9 billion. For 2016, subsidy and discount reimbursements of $11.1 billion exceeded payments of $10.0 billion by $1.1 billion. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 7 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

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

Administrative services fees

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

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

Our TRICARE members are served by both in-network and out-of-network providers in accordance with our contracts. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2018, health care cost reimbursements and payments were each

approximately $5.6 billion, with reimbursements exceeding payments by $38 million for the year. For 2017, health care cost reimbursements and payments were each approximately $3.4 billion, with reimbursements exceeding payments by $11 million for the year. For 2016, health care cost reimbursements and payments were each approximately $3.3 billion with payments exceeding reimbursements by $25 million for the year.

Receivables

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

At December 31, 2018 and 2017, accounts receivable related to services were $123 million and $180 million, respectively. For the year ended December 31, 2018, we had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the consolidated balance sheet at December 31, 2018.

For the year ended December 31, 2018, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price), was not material. Further, revenue expected to be recognized in any future year related to remaining performance obligations was not material.

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 7, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates receivable was $1.3 billion at December 31, 2018 and $1.2 billion at December 31, 2017.

Policy Acquisition Costs

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

Life insurance, annuities, certain health and other supplemental, and, prior to the sale of our KMG subsidiary in 2018, long term care policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 18.

Long-Lived Assets

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

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

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

recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Equity Method Investments

We use the equity method of accounting for equity investments in companies where we are able to exercise significant influence, but not control, over operating and financial policies of the investee. Judgment regarding the level of influence over each equity method investment includes considering key factors such as our ownership interest, representation on the board of directors, organizational structure, participation in policy-making decisions and material intra-entity transactions.

Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by our share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies. Our proportionate share of the net income or loss of these companies is included in consolidated net income. Investment amounts in excess of our share of an investee's net assets are amortized over the life of the related asset creating the excess. Excess goodwill is not amortized.

We evaluate equity method investments for impairment whenever events or changes in circumstances indicate that the carrying amount of the investment might not be recoverable. Factors considered by us when reviewing an equity method investment for impairment include the length of time (duration) and the extent (severity) to which the fair value of the equity method investment has been less than carrying value, the investee's financial condition and near-term prospects and the intent and ability to hold the investment for a period of time sufficient to allow for anticipated recovery. An impairment that is other-than-temporary is recognized in the period identified.

See Note 4 for further information.

Goodwill and Definite-Lived Intangible Assets

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

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our clinical and provider reporting units in our Healthcare Services segment. The margin on the clinical reporting unit would decline to less than 10% after factoring in a 100 basis point increase in the discount rate. The provider reporting unit, while not falling beneath this threshold, was closer than any of our other reporting units. The clinical and provider reporting units account for $524 million and $730 million, respectively, of goodwill. Impairment tests completed for 2018, 2017, and 2016 did not result in an impairment loss.

Definite-lived intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Definite-lived intangible assets are amortized over the useful life generally using the straight-line method. We review definite-lived intangible assets for impairment under our long-lived asset policy.

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

Benefits Payable and Benefits Expense Recognition

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

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

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

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

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

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

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

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise. In 2016, we increased our existing $176 million premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year by $208 million. During 2016, the $384 million current period losses were applied to the premium deficiency liability for the 2016 coverage year.

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

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies including life insurance, annuities, certain health and other supplemental, and prior to its sale in 2018, long-term care policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on industry actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs. During 2016, we recorded a loss for a premium deficiency as discussed further in Note 18.

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

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Book Overdraft

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

Income Taxes

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

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

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model.

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

Earnings Per Common Share

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

Additional detail regarding earnings per common share is included in Note 14.

Fair Value

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

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

Level 2 – Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than

exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

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

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

Fair value of privately held debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows.

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board, or FASB, issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not included in the scope of this new guidance. Accordingly, our premiums revenue and investment income, collectively representing approximately 97% of our consolidated external revenues for the year ended December 31, 2018, are not included in the scope of the new guidance. We adopted the new standard effective January 1, 2018, using the modified retrospective approach. As the majority of our revenues are not subject to the new guidance and the remaining revenues' accounting treatment did not materially differ from pre-existing accounting treatment, the adoption of the new standard did not have a material impact on our consolidated results of operations, financial condition, cash flows, or related disclosures.

Accounting Pronouncements Effective in Future Periods

In February 2016, the FASB issued new guidance related to accounting for leases which requires lessees to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). We adopted the new standard effective January 1, 2019, as allowed, using the modified retrospective approach. We elected the package of practical expedients permitted under the transition guidance within the new standard, which among other things, allows us to carryforward the historical lease classification without restating comparative prior periods. We made a permitted accounting policy election to not apply the new guidance to leases with an initial term of 12 months or less. We will recognize those lease payments in the Consolidated Statements of Operations on a straight-line basis over the lease term. The adoption of the standard resulted in recognition of additional lease assets and lease liabilities of

approximately $470 million as of January 1, 2019. We believe the standard will not materially affect our consolidated net earnings, cash flows and liquidity.

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

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

In February 2018, the FASB issued guidance which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the December 22, 2017 enactment of the Tax Cuts and Jobs Act. The new guidance is effective for us beginning January 1, 2019, with early adoption permitted. We early adopted this guidance in the first quarter of 2018 and it did not have a material impact on our results of operations, financial condition or cash flows.

In September 2018, the FASB issued new guidance related to accounting for long-duration contracts of insurers which revises key elements of the measurement models and disclosure requirements for long-duration contracts issued by insurers and reinsurers. The new guidance is effective for us beginning with annual and interim periods in 2021, with earlier adoption permitted, and requires retrospective application to previously issued annual and interim financial statements. We are currently evaluating the impact on our results of operations, financial position and cash flows.

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

3. ACQUISITIONS AND DIVESTITURES

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

On July 2, 2018, we completed the acquisition of a 40% minority interest in the Kindred at Home Division, or Kindred at Home, of Kindred Healthcare, Inc., or Kindred, for cash consideration of approximately $850 million. TPG Capital, or TPG, and Welsh, Carson, Anderson & Stowe, or WCAS, collectively, the Sponsors, along with us jointly created a consortium to purchase all of the outstanding and issued securities of Kindred. Immediately following the closing of that transaction, Kindred at Home and the Specialty Hospital company were separated, with the result being that the Long Term Acute Care and Rehabilitation businesses (the Specialty Hospital Company) are owned by the Sponsors and Kindred at Home is owned by a joint venture owned by the Sponsors and us.

On July 11, 2018, we, along with the same Kindred at Home Sponsors, TPG and WCAS completed the acquisition of privately-held Curo Health Services, or Curo, one of the nation's leading hospice operators providing care to patients at 245 locations in 22 states. The transaction was structured as a merger of Curo with the hospice business of Kindred at Home, and we thereby purchased a 40% minority interest in Curo for cash consideration of approximately $250 million.

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

We account for our 40% investment in Kindred at Home using the equity method of accounting. This investment is reflected as "Equity method investment in Kindred at Home" in our consolidated balance sheets, with our share of income or loss reported as "Equity in net earnings of Kindred at Home" in our consolidated statements of income.

We entered into a shareholders agreement with the Sponsors that provides for certain rights and obligations of each party. The shareholders agreement with the Sponsors includes a put option under which they have the right to require us to purchase their interest in the joint venture starting at the end of year three and ending at the end of year four following the closing. Likewise, we have a call option under which we have the right to require the Sponsors to sell their interest in the joint venture to Humana beginning at the end of 2022 and ending at the end of 2023 following the closing. The put and call options, which are exercisable at a fixed EBITDA multiple and provide a minimum return on the Sponsor's investment if exercised, are measured at fair value each period using a Monte Carlo simulation. The simulation relies on assumptions around Kindred at Home's equity value, risk free interest rates, volatility, and the details specific to the put and call options. The final purchase price allocation resulted in approximately $1 billion being allocated to the investment and $236 million and $291 million allocated to the put and call options, respectively. The fair values of the put option and call option were $224 million and $246 million, respectively, at December 31, 2018. The put option is included within other long-term liabilities and the call option is included within other long-term assets. The change in fair value of the put and call options is reflected as "Other expense, net" in our consolidated statements of income.

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

On August 9, 2018, we completed the sale of our wholly-owned subsidiary, KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, includes our closed block of non-strategic commercial long-term care policies. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. In connection with the sale of KMG, we recognized a pretax loss, including transaction costs, of $786 million and a corresponding $452 million tax benefit.

Prior to the sale of KMG, we entered into reinsurance contracts to transfer the risk associated with certain voluntary benefit and financial protection products previously issued primarily by KIC to a third party. We transferred approximately $245 million of cash to the third party and recorded a commensurate reinsurance recoverable as a result of these transactions. The reinsurance recoverable was included as part of the net assets disposed. There was no material impact to operating results from these reinsurance transactions.

KMG revenues and net income for the 2018 period prior to the date of sale was $182 million and $47 million, respectively. KMG revenues and net loss were $261 million and $117 million, respectively, for the year ended December 31, 2017 and $249 million and $336 million, respectively, for the year ended December 31, 2016.

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

The assets and liabilities of KMG that were disposed of on August 9, 2018 were as follows:

	August 9, 2018
Assets	**(in millions)**
Cash and cash equivalents	$ 805
Receivables, net	3
Investment securities	1,576
Other assets	1,085
Total assets disposed	$ 3,469
Liabilities	
Benefits payable	$ 58
Trade accounts payable and accrued expenses	70
Future policy benefits payable	2,573
Total liabilities disposed	$ 2,701

Other Acquisitions and Divestitures

On March 1, 2018, we acquired the remaining equity interest in MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. The purchase price consisted primarily of $169 million cash, as well as our existing investment in MCCI and a note receivable and a revolving note with an aggregate balance of $383 million. This resulted in a preliminary purchase price allocation to goodwill of $483 million, definite-lived intangible assets of $80 million, and net tangible assets of $24 million. The goodwill was assigned to the Retail and Healthcare Services segments. The definite-lived intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 8 years.

On April 10, 2018, we acquired Family Physicians Group, or FPG, for cash consideration of approximately $185 million, net of cash received. FPG serves Medicare Advantage and Managed Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties. This resulted in a preliminary purchase price allocation to goodwill of $133 million, definite-lived intangible assets of $38 million and net tangible assets of $14 million. The goodwill was assigned to the Retail and Healthcare Services segments. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 5 years.

The purchase price allocations for MCCI and FPG are preliminary, subject to receipt and validation of certain tax related analyses.

During 2017 and 2016, we acquired certain other health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our consolidated statements of income and consolidated balance sheets from the respective acquisition dates.

Acquisition-related costs recognized in each of 2018, 2017 and 2016 were not material to our results of operations. Goodwill and definite-lived intangible assets acquired are partially amortizable as deductible expenses for tax purposes. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

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

4. EQUITY METHOD INVESTMENT

The summarized balance sheet at December 31, 2018 and income statement for the period beginning July 2, 2018 through December 31, 2018 of Kindred at Home in which we hold a 40% equity interest was as follows:

Balance sheet	**December 31, 2018**
	(in millions)
Current assets	$ 536
Non-current assets	4,955
Current liabilities	351
Non-current liabilities	2,708
Shareholders' equity	2,432

Statement of income	**July 2, 2018 through December 31, 2018**
	(in millions)
Revenues	$ 1,587
Expenses	1,451
Net income	27

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

5. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2018 and 2017, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2018				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 419	$ 1	$ (3)	$ 417
Mortgage-backed securities	2,595	3	(54)	2,544
Tax-exempt municipal securities	2,805	3	(37)	2,771
Mortgage-backed securities:				
Residential	55	—	—	55
Commercial	537	—	(14)	523
Asset-backed securities	991	1	(7)	985
Corporate debt securities	3,239	1	(98)	3,142
Total debt securities	$ 10,641	$ 9	$ (213)	$ 10,437
December 31, 2017				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 532	$ 1	$ (2)	$ 531
Mortgage-backed securities	1,625	4	(19)	1,610
Tax-exempt municipal securities	3,884	33	(28)	3,889
Mortgage-backed securities:				
Residential	26	—	—	26
Commercial	455	3	(2)	456
Asset-backed securities	407	1	—	408
Corporate debt securities	5,175	244	(37)	5,382
Total debt securities	$ 12,104	$ 286	$ (88)	$ 12,302

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

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2018 and 2017, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2018						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 179	$ (1)	$ 153	$ (2)	$ 332	$ (3)
Mortgage-backed securities	956	(16)	1,019	(38)	1,975	(54)
Tax-exempt municipal securities	809	(9)	1,648	(28)	2,457	(37)
Mortgage-backed securities:						
Residential	—	—	15	—	15	—
Commercial	372	(8)	133	(6)	505	(14)
Asset-backed securities	824	(7)	40	—	864	(7)
Corporate debt securities	1,434	(35)	1,439	(63)	2,873	(98)
Total debt securities	$ 4,574	$ (76)	$ 4,447	$ (137)	$ 9,021	$ (213)
December 31, 2017						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 273	$ (1)	$ 130	$ (1)	$ 403	$ (2)
Mortgage-backed securities	581	(2)	672	(17)	1,253	(19)
Tax-exempt municipal securities	1,590	(16)	661	(12)	2,251	(28)
Mortgage-backed securities:						
Residential	20	—	3	—	23	—
Commercial	131	(1)	28	(1)	159	(2)
Asset-backed securities	107	—	10	—	117	—
Corporate debt securities	1,297	(10)	804	(27)	2,101	(37)
Total debt securities	$ 3,999	$ (30)	$ 2,308	$ (58)	$ 6,307	$ (88)

Approximately 97% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2018. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 9%. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Our unrealized loss from all securities was generated from approximately 1,210 positions out of a total of approximately 1,500 positions at December 31, 2018. All issuers of securities we own that were trading at an unrealized loss at December 31, 2018 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2018, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we

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

will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2018.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2018, 2017, and 2016:

	2018	2017	2016
	(in millions)		
Gross realized gains	$ 106	$ 35	$ 120
Gross realized losses	(16)	(21)	(24)
Net realized capital gains	$ 90	$ 14	$ 96

There were no material other-than-temporary impairments in 2018, 2017, or 2016.

The contractual maturities of debt securities available for sale at December 31, 2018, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 943	$ 941
Due after one year through five years	2,929	2,873
Due after five years through ten years	1,873	1,810
Due after ten years	718	706
Mortgage and asset-backed securities	4,178	4,107
Total debt securities	$ 10,641	$ 10,437

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

6. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2018 and 2017, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2018				
Cash equivalents	$ 2,024	$ 2,024	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	417	—	417	—
Mortgage-backed securities	2,544	—	2,544	—
Tax-exempt municipal securities	2,771	—	2,771	—
Mortgage-backed securities:				
Residential	55	—	55	—
Commercial	523	—	523	—
Asset-backed securities	985	—	985	—
Corporate debt securities	3,142	—	3,142	—
Total debt securities	10,437	—	10,437	—
Total invested assets	$ 12,461	$ 2,024	$ 10,437	$ —
December 31, 2017				
Cash equivalents	$ 4,564	$ 4,564	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	531	—	531	—
Mortgage-backed securities	1,610	—	1,610	—
Tax-exempt municipal securities	3,889	—	3,889	—
Mortgage-backed securities:				
Residential	26	—	26	—
Commercial	456	—	456	—
Asset-backed securities	408	—	408	—
Corporate debt securities	5,382	—	5,381	1
Total debt securities	12,302	—	12,301	1
Total invested assets	$ 16,866	$ 4,564	$ 12,301	$ 1

The table above does not include the fair value of the put and call options associated with our equity investment in Kindred at Home. See Note 3 for further information.

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

Financial Liabilities

Our debt is recorded at carrying value in our consolidated balance sheets. The carrying value of our senior notes debt outstanding, net of unamortized debt issuance costs, was $4,774 million at December 31, 2018 and $4,770 million at December 31, 2017. The fair value of our senior note debt was $4,885 million at December 31, 2018 and $5,191 million at December 31, 2017. The fair value of our senior note debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities. Due to the short-term nature, carrying value approximates fair value for our term note and commercial paper borrowings. The term loan outstanding and commercial paper borrowings were $1,295 million at December 31, 2018, compared to $150 million at December 31, 2017.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we acquired MCCI, FPG, and other health and wellness related businesses during 2018, 2017, and 2016. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected future cash flows and discount rates used in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2018, 2017, or 2016.

7. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2018 and 2017. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2018		2017	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 15	$ 172	$ 4	$ 101
Trade accounts payable and accrued expenses	(103)	(503)	(255)	(1,085)
Net current liability	(88)	(331)	(251)	$ (984)
Other long-term assets	7	—	—	—
Other long-term liabilities	(89)	—	(28)	—
Net long-term liability	(82)	—	(28)	—
Total net liability	$ (170)	$ (331)	$ (279)	$ (984)

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

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2018 and 2017.

	2018	2017
	(in millions)	
Land	$ 20	$ 20
Buildings and leasehold improvements	766	713
Equipment	890	824
Computer software	2,372	2,003
	4,048	3,560
Accumulated depreciation	(2,313)	(1,976)
Property and equipment, net	$ 1,735	$ 1,584

Depreciation expense was $444 million in 2018, $410 million in 2017, and $388 million in 2016, including amortization expense for capitalized internally developed and purchased software of $298 million in 2018, $287 million in 2017, and $255 million in 2016.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2018 and 2017 were as follows:

	Retail	Group and Specialty	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2017	$ 1,059	$ 261	$ 1,952	$ 3,272
Acquisitions	—	—	9	9
Balance at December 31, 2017	1,059	261	1,961	3,281
Acquisitions	476	—	140	616
Balance at December 31, 2018	$ 1,535	$ 261	$ 2,101	$ 3,897

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2018 and 2017.

	Weighted Average Life	2018			2017		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
		(in millions)					
Other intangible assets:							
Customer contracts/relationships	8.7 years	$ 646	$ 434	$ 212	$ 566	$ 401	$ 165
Trade names and technology	6.4 years	84	83	1	104	84	20
Provider contracts	11.8 years	68	37	31	68	30	38
Noncompetes and other	7.3 years	29	28	1	32	29	3
Total other intangible assets	8.7 years	$ 827	$ 582	$ 245	$ 770	$ 544	$ 226

Amortization expense for other intangible assets was approximately $90 million in 2018, $75 million in 2017, and $77 million in 2016. Amortization expense for 2018 included $12 million associated with the write-off of a trade name value reflecting the re-branding of certain provider assets.

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

The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2019	$ 70
2020	67
2021	34
2022	31
2023	18

10. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Balances at January 1	$ 4,668	$ 4,563	$ 4,976
Less: Premium deficiency reserve	—	—	(176)
Less: Reinsurance recoverables	(70)	(76)	(85)
Balances at January 1, net	4,598	4,487	4,715
Incurred related to:			
Current year	46,385	44,001	45,318
Prior years	(503)	(483)	(582)
Total incurred	45,882	43,518	44,736
Paid related to:			
Current year	(41,736)	(39,496)	(40,852)
Prior years	(3,977)	(3,911)	(4,112)
Total paid	(45,713)	(43,407)	(44,964)
Reinsurance recoverable	95	70	76
Balances at December 31	$ 4,862	$ 4,668	$ 4,563

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

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $503 million in 2018, $483 million in 2017, and $582 million in 2016. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2018, 2017, and 2016.

	Favorable Medical Claims Reserve Development		
	2018	2017	2016
Retail Segment	$ (398)	$ (386)	$ (429)
Group and Specialty Segment	(46)	(40)	(46)
Individual Commercial Segment	(57)	(56)	(106)
Other Businesses	(2)	(1)	(1)
Total	$ (503)	$ (483)	$ (582)

The favorable medical claims reserve development for 2018, 2017, and 2016 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development primarily resulted from our Medicare Advantage and individual commercial medical businesses.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Premium deficiency reserve for short-duration policies	$ —	$ —	$ (176)
Military services	—	—	8
Future policy benefits	—	(22)	439
Total	$ —	$ (22)	$ 271

Military services benefits expense for 2016 in the table above reflect expenses associated with our contracts with the Veterans Administration.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies, which were sold in 2018, as more fully described in Note 18.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our segments as of December 31, 2018, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2016 and 2017 is presented as supplementary information.

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

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

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Balances at January 1	$ 3,963	$ 3,506	$ 3,600
Less: Reinsurance recoverables	(70)	(76)	(85)
Balances at January 1, net	3,893	3,430	3,515
Incurred related to:			
Current year	41,323	38,604	37,212
Prior years	(398)	(386)	(429)
Total incurred	40,925	38,218	36,783
Paid related to:			
Current year	(37,189)	(34,781)	(33,784)
Prior years	(3,386)	(2,974)	(3,084)
Total paid	(40,575)	(37,755)	(36,868)
Reinsurance recoverable	95	70	76
Balances at December 31	$ 4,338	$ 3,963	$ 3,506

At December 31, 2018, benefits payable for our Retail segment included IBNR of approximately $2.9 billion, primarily associated with claims incurred in 2018. The cumulative number of reported claims as of December 31, 2018 was approximately 104.3 million for claims incurred in 2018, 102.1 million for claims incurred in 2017, and 96.2 million for claims incurred in 2016.

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2018, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2016 Unaudited	2017 Unaudited	2018
		(in millions)	
2016	$ 37,212	$ 36,891	$ 36,811
2017		38,604	38,341
2018			41,323
Total			$ 116,475

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

Claims Incurred Year	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31, 2016 Unaudited	2017 Unaudited	2018
		(in millions)	
2016	$ 33,784	$ 36,841	$ 36,811
2017		34,781	38,232
2018			37,189
Total			$ 112,232
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 4,243

Group and Specialty Segment

Activity in benefits payable for our Group and Specialty segment, excluding military services, was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Balances at January 1	$ 568	$ 579	$ 616
Less: Reinsurance recoverables	—	—	—
Balances at January 1, net	568	579	616
Incurred related to:			
Current year	5,466	5,403	5,271
Prior years	(46)	(40)	(46)
Total incurred	5,420	5,363	5,225
Paid related to:			
Current year	(4,957)	(4,843)	(4,700)
Prior years	(514)	(531)	(562)
Total paid	(5,471)	(5,374)	(5,262)
Balances at December 31	$ 517	$ 568	$ 579

At December 31, 2018, benefits payable for our Group and Specialty segment included IBNR of approximately $448 million, primarily associated with claims incurred in 2018. The cumulative number of reported claims as of December 31, 2018 was approximately 10.4 million for claims incurred in 2018, 11.1 million for claims incurred in 2017, and 12.9 million for claims incurred in 2016.

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

The following tables provide information about incurred and paid claims development for the Group and Specialty segment as of December 31, 2018, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2016 Unaudited**	**2017 Unaudited**	**2018**
		(in millions)	
2016	$ 5,271	$ 5,234	$ 5,235
2017		5,403	5,358
2018			5,466
Total			$ 16,059

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2016 Unaudited**	**2017 Unaudited**	**2018**
		(in millions)	
2016	$ 4,700	$ 5,226	$ 5,234
2017		4,843	5,351
2018			4,957
Total			$ 15,542
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 517

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

Individual Commercial Segment

Activity in benefits payable for our Individual Commercial segment, was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Balances at January 1	$ 101	$ 454	$ 741
Less: Premium deficiency reserve	—	—	(176)
Balances at January 1, net	101	454	565
Incurred related to:			
Current year	—	669	3,677
Prior years	(56)	(56)	(106)
Total incurred	(56)	613	3,571
Paid related to:			
Current year	—	(583)	(3,233)
Prior years	(38)	(383)	(449)
Total paid	(38)	(966)	(3,682)
Balances at December 31	$ 7	$ 101	$ 454

At December 31, 2018, benefits payable for our Individual Commercial segment included IBNR of approximately $1 million, associated with claims prior to 2018. The cumulative number of reported claims as of December 31, 2017 was approximately 2.2 million for claims incurred in 2017 and 9.5 million for claims incurred in 2016.

The following tables provide information about incurred and paid claims development for the Individual Commercial segment as of December 31, 2018, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2016 Unaudited	2017 Unaudited	2018
		(in millions)	
2016	$ 3,677	$ 3,621	$ 3,609
2017		669	627
2018			—
Total			$ 4,236

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

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2016 Unaudited**	**2017 Unaudited**	**2018**
		(in millions)	
2016	$ 3,233	$ 3,606	$ 3,609
2017		583	620
2018			—
Total			$ 4,229
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 7

Reconciliation to Consolidated

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

	December 31, 2018
Net outstanding liabilities	
Retail	$ 4,243
Group and Specialty	517
Individual Commercial	7
Benefits payable, net of reinsurance	4,767
Reinsurance recoverable on unpaid claims	
Retail	95
Total benefits payable, gross	$ 4,862

11. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Current provision:			
Federal	$ 139	$ 1,324	$ 921
States and Puerto Rico	58	116	88
Total current provision	197	1,440	1,009
Deferred expense (benefit)	194	132	(71)
Provision for income taxes	$ 391	$ 1,572	$ 938

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

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2018, 2017 and 2016 due to the following:

	2018	2017	2016
		(in millions)	
Income tax provision at federal statutory rate	$ 436	$ 1,407	$ 543
States, net of federal benefit, and Puerto Rico	42	80	41
Tax exempt investment income	(11)	(22)	(20)
Health insurance industry fee	243	—	336
Nondeductible executive compensation	17	36	30
Tax reform	(39)	133	—
KMG sale	(272)	—	—
Other, net	(25)	(62)	8
Provision for income taxes	$ 391	$ 1,572	$ 938

The tax reform law enacted on December 22, 2017 (the "Tax Reform Law") reduced the statutory federal corporate income tax rate to 21 percent from 35 percent, beginning in 2018, and required a mandatory deemed repatriation of undistributed foreign earnings. The rate reduction required a remeasurement of our net deferred tax asset. These items resulted in an estimated increase in our 2017 tax provision of approximately $133 million, including approximately $10 million for the deemed repatriation tax imposed on the undistributed earnings of our Puerto Rico operations. Revisions to our prior estimate for the income tax effects of the Tax Reform Law decreased our 2018 tax provision by approximately $39 million.

The incremental tax benefit on the sale of KMG of $272 million resulted from a tax loss higher than the loss recorded in the statement of income for the year ended December 31, 2018 due to a higher tax basis in KMG than book basis. In addition, the amount reflects our ability to carryback the capital loss to tax years 2015, 2016 and 2017 at the historical tax rate of 35 percent instead of the current tax rate of 21 percent.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled.

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

Principal components of our net deferred tax balances at December 31, 2018 and 2017 were as follows:

	Assets (Liabilities)	
	2018	2017
	(in millions)	
Compensation and other accrued expense	$ 89	$ 138
Benefits payable	79	113
Investment securities	44	—
Net operating loss carryforward	38	53
Capital loss carryforward	15	—
Deferred acquisition costs	17	48
Unearned revenues	9	12
Other	8	1
Future policy benefits payable	—	231
Total deferred income tax assets	299	596
Valuation allowance	(54)	(49)
Total deferred income tax assets, net of valuation allowance	245	547
Depreciable property and intangible assets	(273)	(237)
Prepaid expenses	(52)	(44)
Future policy benefits payable	(5)	—
Investment securities	—	(49)
Total deferred income tax liabilities	(330)	(330)
Total net deferred income tax assets/(liabilities)	$ (85)	$ 217

All deferred tax liabilities and assets are classified as noncurrent in our consolidated balance sheets as other long-term liabilities at December 31, 2018 and as other long-term assets at December 31, 2017.

At December 31, 2018, we had approximately $104 million of net operating losses and $64 million of capital losses to carry forward. These loss carryforwards, if not used to offset future taxable income or capital gain, will expire from 2019 through 2037. Due to limitations and uncertainty regarding our ability to use some of the loss carryforwards and certain other deferred tax assets, a valuation allowance of $54 million was established. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover these deferred tax assets.

We file income tax returns in the United States and Puerto Rico. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2016 and prior years. Our 2017 tax return is in the post-filing review period under the Compliance Assurance Process, or CAP. Our 2018 tax return is under advance review by the IRS under CAP. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2015. We are not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

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

12. DEBT

The carrying value of debt outstanding was as follows at December 31, 2018 and 2017:

	2018	2017
	(in millions)	
Short-term debt:		
Commercial paper	$ 645	150
Term note	650	—
Senior note:		
$400 million, 2.625% due October 1, 2019	399	—
Total short-term debt	$ 1,694	$ 150
Long-term debt:		
Senior notes:		
$400 million, 2.625% due October 1, 2019	$ —	$ 399
$400 million, 2.50% due December 15, 2020	398	397
$400 million, 2.90% due December 15, 2022	396	396
$600 million, 3.15% due December 1, 2022	596	595
$600 million, 3.85% due October 1, 2024	597	595
$600 million, 3.95% due March 15, 2027	594	594
$250 million, 8.15% due June 15, 2038	263	263
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	739	739
$400 million, 4.80% due March 15, 2047	396	396
Total long-term debt	$ 4,375	$ 4,770

Maturities of the short-term and long-term debt for the years ending December 31, are as follows:

For the years ending December 31,	(in millions)
2019	$ 1,697
2020	400
2021	—
2022	1,000
2023	—
Thereafter	3,000

Senior Notes

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes contain a change of control provision that may require us to purchase the notes under certain circumstances. We recognized a loss on extinguishment of debt of approximately $17 million in 2017 for the early redemption of senior notes, which is included in interest expense in the consolidated statements of income.

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

Credit Agreement

Our 5-year, $2.0 billion unsecured revolving credit agreement expires May 2022. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110.0 basis points, varies depending on our credit ratings ranging from 91.0 to 150.0 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15.0 basis points, may fluctuate between 9.0 and 25.0 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive covenants and a financial covenant regarding maximum debt to capitalization of 50% as well as customary events of default. We are in compliance with this financial covenant, with an actual debt to capitalization of 37% as measured in accordance with the credit agreement as of December 31, 2018. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the credit agreement to a maximum of $2.5 billion, through a $500 million incremental loan facility.

At December 31, 2018, we had no borrowings and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2018, we had $2 billion of remaining borrowing capacity (which excludes the uncommitted $500 million incremental loan facility under the credit agreement), none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

Under our commercial paper program we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time not to exceed $2 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2018 was $923 million, with $645 million outstanding at December 31, 2018 compared to $150 million outstanding at December 31, 2017. The outstanding commercial paper at December 31, 2018 had a weighted average annual interest rate of 3.06%.

Term Note

In November 2018, we entered into a $1.0 billion term note agreement with a bank at a variable rate of interest due within one year. We may elect to incur interest at either the bank's base rate or LIBOR plus 115 basis points. The base rate is defined as the higher of the daily federal funds rate plus 50 basis points; or the bank's prime rate; or LIBOR plus 100 basis points. The interest rate in effect at December 31, 2018 was 3.67%. The note is prepayable without penalty. Proceeds were primarily used to fund the November 2018 accelerated stock repurchase agreement. We repaid $350 million prior to December 31, 2018. The term note shares the customary terms and provisions as well as financial covenants of our Credit Agreement, as discussed above.

13. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $197 million in 2018, $217 million in 2017, and $196 million in 2016. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $286.48 on December 31, 2018, approximately 12% of the retirement and savings plan's assets were invested in our common stock, or approximately 1.8 million shares, representing approximately 1.3% of the shares outstanding as of

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

December 31, 2018. At December 31, 2018, approximately 2.0 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. Awards generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

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

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2018, 2017, and 2016:

	2018	2017	2016
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 124	$ 145	$ 106
Stock options	13	12	9
Total stock-based compensation expense	137	157	115
Tax benefit recognized	(21)	(32)	(20)
Stock-based compensation expense, net of tax	$ 116	$ 125	$ 95

Stock-based compensation expense for certain restricted stock in 2017 included a $29 million modification expense for certain awards.

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $49 million in 2018, $68 million in 2017, and $53 million in 2016. There was no capitalized stock-based compensation expense during these years.

At December 31, 2018, there were 13.1 million shares reserved for stock award plans. These reserved shares included giving effect to, under the 2011 Plan, 4.7 million shares of common stock available for future grants assuming all stock options were granted or 2.0 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

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

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock grants also include performance-based conditions generally associated with return on invested capital and strategic membership growth. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $276.62 in 2018, $222.35 in 2017, and $168.12 in 2016. Activity for our restricted stock was as follows for the year ended December 31, 2018:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2017	1,653	$ 171.68
Granted	576	276.62
Vested	(1,045)	185.82
Forfeited	(220)	180.83
Nonvested restricted stock at December 31, 2018	964	$ 213.99

Approximately 12% of the nonvested restricted stock at December 31, 2018 included performance-based conditions.

The fair value of shares vested was $298 million during 2018, $306 million during 2017, and $253 million during 2016. Total compensation expense not yet recognized related to nonvested restricted stock was $156 million at December 31, 2018. We expect to recognize this compensation expense over a weighted-average period of approximately 1.8 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

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

The weighted-average fair value of each option granted during 2018, 2017, and 2016 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2018	2017	2016
Weighted-average fair value at grant date	$ 63.67	$ 49.81	$ 37.12
Expected option life (years)	4.1 years	4.1 years	4.2 years
Expected volatility	26.1%	27.1%	27.6%
Risk-free interest rate at grant date	2.5%	2.0%	1.1%
Dividend yield	0.7%	0.7%	0.7%

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

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

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

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

Activity for our option plans was as follows for the year ended December 31, 2018:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2017	863	$ 181.44
Granted	143	276.01
Exercised	(320)	157.44
Forfeited	(9)	150.59
Options outstanding at December 31, 2018	677	$ 213.17
Options exercisable at December 31, 2018	178	$ 180.76

As of December 31, 2018, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $48 million, and a weighted-average remaining contractual term of 5 years. As of December 31, 2018, exercisable stock options had an aggregate intrinsic value of $19 million, and a weighted-average remaining contractual term of 4.1 years. The total intrinsic value of stock options exercised during 2018 was $43 million, compared with $44 million during 2017 and $18 million during 2016. Cash received from stock option exercises totaled $50 million in 2018, $63 million in 2017, and $14 million in 2016.

Total compensation expense not yet recognized related to nonvested options was $14 million at December 31, 2018. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years.

14. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 1,683	$ 2,448	$ 614
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	137,486	144,493	149,375
Dilutive effect of:			
Employee stock options	194	172	219
Restricted stock	723	920	1,323
Shares used to compute diluted earnings per common share	138,403	145,585	150,917
Basic earnings per common share	$ 12.24	$ 16.94	$ 4.11
Diluted earnings per common share	$ 12.16	$ 16.81	$ 4.07
Number of antidilutive stock options and restricted stock awards excluded from computation	223	539	748

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

15. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2016, 2017, and 2018 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2016	$1.16	$172
2017	$1.49	$216
2018	$1.90	$262

On November 2, 2018, the Board declared a cash dividend of $0.50 per share that was paid on January 25, 2019 to stockholders of record on December 31, 2018, for an aggregate amount of $68 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2019, the Board declared a cash dividend of $0.55 per share payable on April 26, 2019 to stockholders of record on March 29, 2019.

Stock Repurchases

Our Board of Directors may authorize the purchase of our common shares. Under our share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing.

On February 14, 2017, our Board of Directors authorized the repurchase of up to $2.25 billion of our common shares expiring on December 31, 2017, exclusive of shares repurchased in connection with employee stock plans.

On February 16, 2017, we entered into an accelerated share repurchase agreement, the February 2017 ASR, with Goldman, Sachs & Co. LLC, or Goldman Sachs, to repurchase $1.5 billion of our common stock as part of the $2.25 billion share repurchase authorized on February 14, 2017. On February 22, 2017, we made a payment of $1.5 billion to Goldman Sachs from available cash on hand and received an initial delivery of 5.83 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $1.2 billion increase in treasury stock, which reflected the value of the initial 5.83 million shares received upon initial settlement, and a $300 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the February 2017 ASR. Upon settlement of the February 2017 ASR on August 28, 2017, we received an additional 0.84 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the agreement of $224.81, less a discount and subject to adjustments pursuant to the terms and conditions of the February 2017 ASR, bringing the total shares received under this program to 6.67 million. In addition, upon settlement we reclassified the $300 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock. Subsequent to settlement of the February 2017 ASR, we repurchased an additional 3.04 million shares in the open market, utilizing the remaining $750 million of the $2.25 billion authorization prior to expiration.

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans.

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

On December 21, 2017, we entered into an accelerated stock repurchase agreement, the December 2017 ASR, with Bank of America, N.A., or BofA, to repurchase $1.0 billion of our common stock as part of the $3.0 billion share repurchase program authorized on December 14, 2017. On December 22, 2017, we made a payment of $1.0 billion to BofA from available cash on hand and received an initial delivery of 3.28 million shares of our common stock from BofA based on the then current market price of Humana common stock. The payment to BofA was recorded as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 3.28 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by BofA pending final settlement of the December 2017 ASR. Upon settlement of the ASR on March 26, 2018, we received an additional 0.46 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the ASR Agreement of $267.55, bringing the total shares received under this program to 3.74 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by BofA from capital in excess of par value to treasury stock.

On November 28, 2018, we entered into an accelerated stock repurchase agreement, the November 2018 ASR, with Goldman Sachs to repurchase $750 million of our common stock as part of the $3.0 billion share repurchase program authorized by the Board of Directors on December 14, 2017. On November 29, 2018, we made a payment of $750 million to Goldman Sachs from available cash on hand and received an initial delivery of 1.94 million shares of our common stock from Goldman Sachs. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $600 million increase in treasury stock, which reflects the value of the initial 1.94 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the November 2018 ASR. The final number of shares that we may receive, or be required to remit, under the agreement will be determined based on the daily volume-weighted average share price of our common stock over the term of the agreement, less a discount and subject to adjustments pursuant to the terms and conditions of the agreement. Final settlement under the November 2018 ASR is expected to occur by the end of the first quarter of 2019. The agreement contains provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement may be accelerated or extended or the agreement may be terminated early by Goldman Sachs or Humana, and various acknowledgments and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our common stock from Goldman Sachs or we may be required to make a payment. If we are obligated to make payment, we may elect to satisfy such obligation in cash or shares of our common stock.

Our remaining repurchase authorization was approximately $1,176 million as of February 21, 2019, excluding the $150 million pending final settlement of our November 28, 2018 ASR.

Excluding shares acquired in connection with employee stock plans, share repurchases were as follows during the years ended December 31, 2018, 2017 and 2016.

		2018		2017		2016	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
				(in millions)			
February 2017	2,250	—	—	9.71	2,250	—	—
December 2017	3,000	3.07	1,024	3.28	800	—	—
Total repurchases		3.07	$1,024	12.99	$3,050	—	$ —

In connection with employee stock plans, we acquired 0.4 million common shares for $116 million in 2018, 0.5 million common shares for $115 million in 2017, and 0.6 million common shares for $104 million in 2016.

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

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $7.6 billion and $8.0 billion as of December 31, 2018 and 2017, respectively, which exceeded aggregate minimum regulatory requirements of $5.2 billion and $4.8 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2019 is approximately $1 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $2.3 billion in 2018, $1.4 billion in 2017, and $0.8 billion in 2016.

16. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Leases

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Rent expense	$ 167	$ 204	$ 179
Sublease rental income	(32)	(33)	(26)
Net rent expense	$ 135	$ 171	$ 153

Future annual minimum payments due subsequent to December 31, 2018 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31,:			
2019	$ 147	$ (13)	$ 134
2020	113	(12)	101
2021	96	(10)	86
2022	79	(9)	70
2023	34	(9)	25
Thereafter	50	(23)	27
Total	$ 519	$ (76)	$ 443

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

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $240 million in 2019, $201 million in 2020, $136 million in 2021, $98 million in 2022, and $61 million in 2023. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2018, we were not involved in any SPE transactions.

Guarantees and Indemnifications

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

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

Government Contracts

Our Medicare products, which accounted for approximately 80% of our total premiums and services revenue for the year ended December 31, 2018, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2019, and all of our product offerings filed with CMS for 2019 have been approved.

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

providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

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

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We are studying the Proposed Rule and CMS' underlying analysis contained therein. We believe, however, that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and we expect to provide substantive comments to CMS on the Proposed

Rule as part of the notice-and-comment rulemaking process. We are also evaluating the potential impact of the Proposed Rule, and any related regulatory, industry or company reactions, all or any of which could have a material adverse effect on our results of operations, financial position, or cash flows.

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

We believe that CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has filed a motion for reconsideration related to certain aspects of the Federal District Court's opinion and has simultaneously filed a notice to appeal the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2018, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2018, primarily consisted of the TRICARE T2017 East Region contract replacing the 5-year T3 South Region contract that expired on December 31, 2017. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our state-based Medicaid business accounted for approximately 4% of our total premiums and services revenue for the year ended December 31, 2018. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Florida for Long Term Support Services (LTSS), and in Illinois for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program.

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

Legal Proceedings and Certain Regulatory Matters

As previously disclosed, the Civil Division of the United States Department of Justice provided us with an information request in December 2014, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by

us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned *United States of America ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by us in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by us under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. We take seriously our obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations since the transfer to the Western District of Kentucky. We have engaged in active discovery with the relator who has pursed the matter on behalf of the United States for the past year, and expect that discovery process to conclude in the near future and for the Court to consider our motion for summary judgment.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under Health Care Reform , for years 2014, 2015 and 2016. Our case has been stayed by the Court, pending resolution of similar cases filed by other insurers. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid risk corridor payments as of December 31, 2018. We have fully recognized all liabilities due to the federal government that we have incurred under the risk corridor program, and have paid all amounts due to the federal government as required. There is no assurance that we will prevail in the lawsuit.

Other Lawsuits and Regulatory Matters

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

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate and payment disputes, including disputes over reimbursement rates required by statute, general contractual matters, intellectual property matters, and challenges to subrogation practices. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the individual may continue to

prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of non-performance of contractual obligations to providers, members, and others, including failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

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

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

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

17. SEGMENT INFORMATION

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

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes our services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our investment in Kindred at Home. The Individual Commercial segment consisted of our individual commercial fully-insured medical health insurance business, which we exited beginning January 1, 2018. We report under the category of Other Businesses those businesses that do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies, which were sold in 2018.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of Humana

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

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

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $13.4 billion in 2018, $13.5 billion in 2017, and $13.4 billion in 2016. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $129 million in 2018, $107 million in 2017, and $111 million in 2016.

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

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

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2018							
External revenues							
Premiums:							
Individual Medicare Advantage	$ 35,656	$ —	$ —	$ —	$ —	$ —	$ 35,656
Group Medicare Advantage	6,103	—	—	—	—	—	6,103
Medicare stand-alone PDP	3,584	—	—	—	—	—	3,584
Total Medicare	45,343	—	—	—	—	—	45,343
Fully-insured	510	5,444	—	8	—	—	5,962
Specialty	—	1,359	—	—	—	—	1,359
Medicaid and other	2,255	—	—	—	22	—	2,277
Total premiums	48,108	6,803	—	8	22	—	54,941
Services revenue:							
Provider	—	—	404	—	—	—	404
ASO and other	11	835	—	—	4	—	850
Pharmacy	—	—	203	—	—	—	203
Total services revenue	11	835	607	—	4	—	1,457
Total external revenues	48,119	7,638	607	8	26	—	56,398
Intersegment revenues							
Services	—	18	16,840	—	—	(16,858)	—
Products	—	—	6,330	—	—	(6,330)	—
Total intersegment revenues	—	18	23,170	—	—	(23,188)	—
Investment income	136	23	34	—	110	211	514
Total revenues	48,255	7,679	23,811	8	136	(22,977)	56,912
Operating expenses:							
Benefits	40,925	5,420	—	(70)	77	(470)	45,882
Operating costs	5,327	1,810	22,905	4	6	(22,527)	7,525
Depreciation and amortization	270	88	163	—	—	(116)	405
Total operating expenses	46,522	7,318	23,068	(66)	83	(23,113)	53,812
Income from operations	1,733	361	743	74	53	136	3,100
Loss on sale of business	—	—	—	—	—	786	786
Interest expense	—	—	—	—	—	218	218
Other expense, net	—	—	—	—	—	33	33
Income (loss) before income taxes and equity in earnings	1,733	361	743	74	53	(901)	2,063
Equity in net earnings of Kindred at Home	—	—	11	—	—	—	11
Segment earnings (losses)	$ 1,733	$ 361	$ 754	$ 74	$ 53	$ (901)	$ 2,074

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 81% for 2018, compared to 79% for 2017, and 75% for 2016.

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

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2017							
Revenues—external customers							
Premiums:							
Individual Medicare Advantage	$ 32,720	$ —	$ —	$ —	$ —	$ —	$ 32,720
Group Medicare Advantage	5,155	—	—	—	—	—	5,155
Medicare stand-alone PDP	3,702	—	—	—	—	—	3,702
Total Medicare	41,577	—	—	—	—	—	41,577
Fully-insured	478	5,462	—	947	—	—	6,887
Specialty	—	1,310	—	—	—	—	1,310
Medicaid and other	2,571	—	—	—	35	—	2,606
Total premiums	44,626	6,772	—	947	35	—	52,380
Services revenue:							
Provider	—	—	258	—	—	—	258
ASO and other	10	626	—	—	8	—	644
Pharmacy	—	—	80	—	—	—	80
Total services revenue	10	626	338	—	8	—	982
Total revenues—external customers	44,636	7,398	338	947	43	—	53,362
Intersegment revenues							
Services	—	20	17,293	—	—	(17,313)	—
Products	—	—	6,292	—	—	(6,292)	—
Total intersegment revenues	—	20	23,585	—	—	(23,605)	—
Investment income	90	31	35	4	87	158	405
Total revenues	44,726	7,449	23,958	951	130	(23,447)	53,767
Operating expenses:							
Benefits	38,218	5,363	—	544	131	(760)	43,496
Operating costs	4,292	1,590	22,848	201	12	(22,376)	6,567
Merger termination fee and related costs, net	—	—	—	—	—	(936)	(936)
Depreciation and amortization	238	84	143	13	—	(100)	378
Total operating expenses	42,748	7,037	22,991	758	143	(24,172)	49,505
Income (loss) from operations	1,978	412	967	193	(13)	725	4,262
Interest expense	—	—	—	—	—	242	242
Income (loss) before income taxes and equity in earnings	1,978	412	967	193	(13)	483	4,020
Equity in net earnings of Kindred at Home	—	—	—	—	—	—	—
Segment earnings (losses)	$ 1,978	$ 412	$ 967	$ 193	$ (13)	$ 483	$ 4,020

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

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2016							
Revenues—external customers							
Premiums:							
Individual Medicare Advantage	$ 31,863	$ —	$ —	$ —	$ —	$ —	$ 31,863
Group Medicare Advantage	4,283	—	—	—	—	—	4,283
Medicare stand-alone PDP	4,009	—	—	—	—	—	4,009
Total Medicare	40,155	—	—	—	—	—	40,155
Fully-insured	428	5,405	—	3,064	—	—	8,897
Specialty	—	1,279	—	—	—	—	1,279
Medicaid and other	2,640	12	—	—	38	—	2,690
Total premiums	43,223	6,696	—	3,064	38	—	53,021
Services revenue:							
Provider	—	—	278	—	—	—	278
ASO and other	6	643	1	—	10	—	660
Pharmacy	—	—	31	—	—	—	31
Total services revenue	6	643	310	—	10	—	969
Total revenues—external customers	43,229	7,339	310	3,064	48	—	53,990
Intersegment revenues							
Services	—	22	18,979	—	—	(19,001)	—
Products	—	—	5,993	—	—	(5,993)	—
Total intersegment revenues	—	22	24,972	—	—	(24,994)	—
Investment income	90	25	30	5	66	173	389
Total revenues	43,319	7,386	25,312	3,069	114	(24,821)	54,379
Operating expenses:							
Benefits	36,783	5,233	—	3,301	617	(927)	45,007
Operating costs	4,650	1,727	24,073	601	16	(23,894)	7,173
Merger termination fee and related costs, net	—	—	—	—	—	104	104
Depreciation and amortization	196	82	143	36	1	(104)	354
Total operating expenses	41,629	7,042	24,216	3,938	634	(24,821)	52,638
Income (loss) from operations	1,690	344	1,096	(869)	(520)	—	1,741
Gain on sale of business	—	—	—	—	—	—	—
Interest expense	—	—	—	—	—	189	189
Income (loss) before income taxes and equity in earnings	1,690	344	1,096	(869)	(520)	(189)	1,552
Equity in net earnings of Kindred at Home	—	—	—	—	—	—	—
Segment earnings (losses)	$ 1,690	$ 344	$ 1,096	$ (869)	$ (520)	$ (189)	$ 1,552

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

Premiums revenue for our Individual Commercial segment for 2016 includes a reduction of $583 million associated with the write-off of commercial risk corridor receivables.

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

18. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for less than 1% of our consolidated premiums and services revenue for the year ended December 31, 2018 and 2017. We use long-duration accounting for life insurance, annuities, certain health and other supplemental products and, prior to its sale in 2018, long-term care policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

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

The table below presents deferred acquisition costs and future policy benefits payable associated with our long-duration insurance products for the years ended December 31, 2018 and 2017.

	2018		2017	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$ 36	$ —	$ 103	$ —
Trade accounts payable and accrued expenses	—	—	—	(56)
Long-term liabilities	—	(219)	—	(2,923)
Total asset (liability)	$ 36	$ (219)	$ 103	$ (2,979)

The decline in the balances of the deferred acquisition costs and future benefits payable reflects the sale of KMG on August 9, 2018. In addition, future policy benefits payable include amounts of $217 million at December 31, 2018 and $199 million at December 31, 2017 which are subject to 100% coinsurance agreements as more fully described in Note 19.

Benefit expense reflects no net increase in future policy benefit payable in 2018, a net reduction of $22 million in 2017 and a net increase of $439 million in 2016. The 2016 amount reflects the net change of $505 million associated with our closed block of long-term care insurance policies, which were sold in 2018 as discussed further below. Amortization of deferred acquisition costs included in operating costs was $48 million in 2018, $71 million in 2017, and $67 million in 2016.

All three years include the effect of the release of reserves and accelerating deferred acquisition amortization costs of existing previously underwritten individual commercial medical members transitioning to policies compliant with the Health Care Reform Law. Deferred acquisition costs included $3 million associated with our individual commercial

medical policies at December 31, 2017. Future policy benefits payable associated with our individual commercial medical policies were $19 million at December 31, 2017. There were no remaining balances at December 31, 2018. We have exited our individual commercial medical business effective January 1, 2018.

Future policy benefits payable included $2.3 billion at December 31, 2017 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. As described in Note 3, on August 9, 2018, we completed the sale of KMG. Future policy benefits payable included amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was additional liability of $168 million at December 31, 2017. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provided nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual premium rate increase, interest, morbidity, mortality, persistency, and maintenance expense assumptions from those assumed in our reserves were particularly significant to our closed block of long-term care insurance policies. We monitored the loss experience of these long-term care insurance policies and, when necessary, applied for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience varied from our loss recognition date assumptions, material adjustments to reserves were required.

During 2016, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2013 loss recognition date, particularly as they related to emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies. Based on this deterioration, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2016 we recorded $505 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $659 million partially offset by a related reinsurance recoverable of $154 million included in other long-term assets. During 2017, we performed loss recognition testing comparing our existing future policy benefits payable with the present value of future gross premiums associated with our closed block of long-term care insurance policies and determined that no premium deficiency existed at December 31, 2017.

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, annuities in run-off status and, prior to its sale in 2018, long-term care, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods

used to determine future policy benefits payable as detailed in Note 2. Reinsurance recoverables, included in other current and long-term assets, were $314 million at December 31, 2018 and $824 million at December 31, 2017. The decline in the balances reflects the sale of KMG on August 9, 2018. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 99% at December 31, 2018 and approximately 33% at December 31, 2017. Premiums ceded were $976 million in 2018, $969 million in 2017 and $842 million in 2016. Benefits ceded were $980 million in 2018, $844 million in 2017, and $767 million in 2016. Ceded premium and benefits reflect the activity associated with ceding all risk under a Medicaid contract to a third party reinsurer.

We evaluate the financial condition of our reinsurers on a regular basis. Protective Life Insurance Company with $177 million in reinsurance recoverables is well-known and well-established with a AM Best rating of A+ (superior) at December 31, 2018 . The remaining reinsurance recoverables of $137 million are divided between 10 other reinsurers, with $110 million subject to funds withheld accounts or other financial guarantees supporting the repayment of these amounts.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Humana Inc. and its subsidiaries (the "Company") as of December 31, 2018 and 2017, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2018, including the related notes and financial statement schedules listed in the index appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017**,** and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in

accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 21, 2019

We have served as the Company's auditor since 1968.

Humana Inc.
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31, 2018 and 2017 follows:

	2018			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 14,279	$ 14,259	$ 14,206	$ 14,168
Income before income taxes and equity in net earnings	707	19	901	436
Net income	491	193	644	355
Basic earnings per common share	$ 3.56	$ 1.40	$ 4.68	$ 2.60
Diluted earnings per common share (1)	$ 3.53	$ 1.39	$ 4.65	$ 2.58

	2017			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 13,762	$ 13,534	$ 13,282	$ 13,189
Income before income taxes	1,689	1,042	799	490
Net income	1,115	650	499	184
Basic earnings per common share (1)	$ 7.54	$ 4.49	$ 3.46	$ 1.30
Diluted earnings per common share (1)	$ 7.49	$ 4.46	$ 3.44	$ 1.29

(1) The calculation of earnings per common share is based on the weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2018, we as the principal executive officer, the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2018. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2018, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2018 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on page 134.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

Set forth below are names and ages of all of our current executive officers as of February 1, 2019, their positions, and the date first elected an officer:

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	56	President and Chief Executive Officer, Director	12/11	(1)
Vishal Agrawal, M.D.	44	Chief Strategy and Corporate Development Officer	12/18	(2)
Roy A. Beveridge, M.D.	61	Chief Medical Officer	06/13	(3)
Elizabeth D. Bierbower	60	Segment President	03/17	(4)
Jody L. Bilney	57	Chief Consumer Officer	04/13	(5)
Sam M. Deshpande	54	Chief Risk Officer	07/17	(6)
William K. Fleming, PharmD	51	Segment President, Healthcare Services	03/17	(7)
Christopher H. Hunter	50	Segment President, Group Business	01/14	(8)
Timothy S. Huval	52	Chief Human Resources Officer	12/12	(9)
Brian A. Kane	46	Chief Financial Officer	06/14	(10)
Brian P. LeClaire	58	Chief Information Officer	08/11	(11)
Joseph C. Ventura	42	Chief Legal Officer and Corporate Secretary	02/19	(12)
T. Alan Wheatley	51	Segment President, Retail	03/17	(13)
Cynthia H. Zipperle	56	Senior Vice President and Chief Accounting Officer	12/14	(14)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Dr. Agrawal serves as Chief Strategy and Corporate Development Officer, having joined the company in December 2018. Prior to joining the company, Dr. Agrawal was Senior Advisor for The Carlyle Group L.P., having held that position from October 2017 to December 2018. Previously, Dr. Agrawal was President and Chief Growth Officer of Ciox Health, the largest health information exchange and release of information services

organization in the U.S. from December of 2015 to October 2018. Prior to joining Ciox Health, Dr. Agrawal served as President of Harris Healthcare Solutions from January 2013 to December 2015.

(3) Dr. Beveridge currently serves as Chief Medical Officer, having held this position since joining the Company in June 2013. Prior to joining the Company, Dr. Beveridge served as Chief Medical Officer for McKesson Specialty Health from December 2010 until June 2013. Prior to McKesson's acquisition of US Oncology, Dr. Beveridge served as the Executive Vice President and Medical Director at US Oncology from September 2009 through December 2010.

(4) Ms. Bierbower currently serves as Segment President, having held this position since August 2018. She is responsible for creating a new operating model and member experience that reduces friction in the system and helps members engage in and manage their health. Prior to that, she served as the Segment President, Group Business, and also previously led the Company's Specialty Benefits area, including dental, vision, life, disability and workplace voluntary benefits. Ms. Bierbower joined the Company in 2001.

(5) Ms. Bilney currently serves as Chief Consumer Officer, having held this position since joining the Company in April 2013. Prior to joining the Company, Ms. Bilney served as Executive Vice President and Chief Brand Officer for Bloomin' Brands, Inc. from 2006 until April 2013.

(6) Mr. Deshpande currently serves as Chief Risk Officer, having held this position since joining the Company in July 2017. Before joining Humana, Mr. Deshpande spent 17 years at Capital One in key leadership positions, most recently as Business Chief Risk Officer for the U.S. and international card business. He previously served as the Business Chief Risk Officer and Head of Enterprise Services for the Financial Services Division, responsible for Business Risk, Data Science, Data Quality, Process Excellence and Project Management. He also led marketing and analysis for the Home Loans, Auto Finance, and Credit Card businesses, with responsibilities for business strategy, credit, product and marketing.

(7) Mr. Fleming currently serves as Segment President, Healthcare Services, where he is responsible for Humana's clinical and pharmacy businesses that service all Humana segments, having held this position since March of 2017. Prior to that, he served as President of the Company's pharmacy business. Mr. Fleming joined the Company in 1994.

(8) Mr. Hunter currently serves as Segment President, Group Business, having held this position since August 2018. Prior to that, he served as Chief Strategy Officer from joining the company in January 2014 until August 2018. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(9) Mr. Huval currently serves as Chief Human Resources Officer, having been elected to this position in December 2012. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(10) Mr. Kane currently serves as Chief Financial Officer, having been elected to this position in June 2014. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(11) Mr. LeClaire currently serves as Chief Information Officer, having held this position since January 2014. Prior to that, he served as Senior Vice President and Chief Service and Information Officer from August 2011 to January 2014, and as Chief Technology Officer from 2002 to August 2011. Mr. LeClaire joined the Company in August 1999.

(12) Mr. Ventura currently serves as Chief Legal Officer and Corporate Secretary. He joined the Company in January 2009 and since then has held various positions of increasing responsibility in the Company's Law Department, including most recently, Senior Vice President, Associate General Counsel & Corporate Secretary from July 2017 until February 2019.

(13) Mr. Wheatley currently serves as Segment President, Retail, having held this position since March 2017. During his 25-year career with the Company, Mr. Wheatley has served in a number of key leadership roles, including Vice President of Medicare Service Operations and President of the East Region, one of the Company's key Medicare geographies.

(14) Mrs. Zipperle currently serves as Senior Vice President, Chief Accounting Officer, having held this position since December 2014. Mrs. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

Section 16(a) Beneficial Ownership Reporting Compliance

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of such Proxy Statement.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day. All employees and directors are required to annually affirm in writing their acceptance of the code. The Humana Inc. Ethics Every Day was adopted by our Board of Directors in June 2014, replacing a previous iteration of our Code of Ethics and Business Conduct – the Humana Inc. Principles of Business Ethics – as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Humana Inc. Ethics Every Day is available on our web site at www.humana.com, and any waiver of the application of the Ethics Every Day with respect to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on our Internet web site is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;

- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our by-laws and Certificate of Incorporation;
- our Majority Vote policy;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;
- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Corporate Governance – Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, key employees, and consultants. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2018 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	677,648	$ 213.171	4,673,360	(2)(3)
Equity compensation plans not approved by security holders	—	—	—	
Total	677,648	$ 213.171	4,673,360	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 13.
(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) Of the number listed above, 2,040,768 can be issued as restricted stock at December 31, 2018 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan).

The information under the captions “Security Ownership of Certain Beneficial Owners of Company Common Stock” and “Security Ownership of Directors and Executive Officers” in our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the captions “Certain Transactions with Management and Others” and “Corporate Governance – Independent Directors” of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption “Audit Committee Report” of such Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Condensed Financial Information at December 31, 2018 and 2017 and for the years ended December 31, 2018, 2017 and 2016
Schedule II	Valuation and Qualifying Accounts for the years ended December 31, 2018, 2017 and 2016

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) Humana Inc. Amended and Restated By-Laws of Humana Inc., effective as of December 14, 2017 (incorporated herein by reference to Exhibit 3(b) to Humana Inc.'s Current Report on Form 8-K filed on December 14, 2017).

4(a) Indenture, dates as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(b) First Supplemental Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(c) Second Supplemental Indenture, dated as of May 31, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on May 31, 2006, File No.001-05975).

(d) Third Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(e) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(f) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006, Req. No. 333-132878).

(g)	There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 12 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.
(h)	Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).
(i)	Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).
(j)	Seventh Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York, Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(k)	Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(l)	Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(m)	Tenth Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017.
(n)	Eleventh Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017.
(o)	Twelfth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017.
(p)	Thirteenth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017.
10(a)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(b)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(c)*	Humana Inc. Executive Management Incentive Compensation Plan, as amended and restated February 21, 2008 (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 24, 2008).
(d)*	Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999, File No. 001-05975).
(e)*	The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).

(f)*†	Humana Inc. Executive Severance Policy, effective as of March 1, 2019.
(g)*	Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).
(h)*	Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 18, 2011).
(i)*	Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994, File No. 001-05975).
(j)*	Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).
(k)*	Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).
(l)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(m)*	Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.
(n)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(q) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(o)	Five-Year $2 Billion Amended and Restated Credit Agreement , dated as of May 22, 2017, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent and as CAF Loan Agent, Bank of America, N.A. as Syndication Agent, Citibank, N.A., PNC Bank, National Association, U.S. Bank National Association, and Wells Fargo Bank, National Association, as Documentation Agents, and J.P. Morgan Chase Bank, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Citigroup Global Markets, Inc., PNC Capital Markets LLC, U.S. Bank National Association, and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on May 22, 2017).
(p)	Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(q)	Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(r)	Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(s)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(t)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(u)	Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(v)	Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005, File No. 001-05975).
(w)*	Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).
(x)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(y)*	Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).
(z)*	Amendment No. 2, dated as of August 16, 2018, to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated as of February 27, 2014 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.s Current Report on Form 8-K, filed on August 20, 2018).
(aa)*†	Humana Inc. Change in Control Policy, effective March 1, 2019.
(bb)	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 7, 2014).
(cc)	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(dd)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(ee)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K filed on February 16, 2018).
(ff)*†	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions).
(gg)*†	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan.
(hh)*†	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan.
(ii)*†	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (Non-Qualified Stock Options).
(jj)*†	Humana Inc. Compensation Recoupment Policy, effective February 21, 2019.
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).

31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.
101	The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2018 and 2017; (ii) the Consolidated Statements of Income for the years ended December 31, 2018, 2017 and 2016; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017 and 2016; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2018, 2017, and 2016; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017 and 2016; and (vi) Notes to Consolidated Financial Statements.

*Exhibits 10(a) through and including 10(n), and Exhibits 10(w) through and including 10(aa), as well as Exhibits 10(cc) through and including Exhibit 10(jj) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Exchange Act, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2018	2017
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 265	$ 383
Investment securities	313	305
Receivable from operating subsidiaries	1,306	1,042
Other current assets	628	245
Total current assets	2,512	1,975
Property and equipment, net	1,209	1,091
Investments in subsidiaries	16,951	16,810
Equity method investment in Kindred at Home	1,047	—
Other long-term assets	359	426
Total assets	$ 22,078	$ 20,302
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 4,487	$ 4,311
Current portion of notes payable to operating subsidiaries	28	28
Book overdraft	38	41
Short-term debt	1,694	150
Other current liabilities	791	896
Total current liabilities	7,038	5,426
Long-term debt	4,375	4,770
Other long-term liabilities	504	264
Total liabilities	11,917	10,460
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,594,841 shares issued at December 31, 2018 and 198,572,458 shares issued at December 31, 2017	33	33
Capital in excess of par value	2,535	2,445
Retained earnings	15,072	13,670
Accumulated other comprehensive income (loss)	(159)	19
Treasury stock, at cost, 63,028,169 shares at December 31, 2018 and 60,893,762 shares at December 31, 2017	(7,320)	(6,325)
Total stockholders' equity	10,161	9,842
Total liabilities and stockholders' equity	$ 22,078	$ 20,302

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2018	2017	2016
	(in millions)		
Revenues:			
Management fees charged to operating subsidiaries	$ 1,666	$ 1,864	$ 1,683
Investment and other income, net	30	57	42
	1,696	1,921	1,725
Expenses:			
Operating costs	1,468	1,801	1,519
Merger termination fee and related costs, net	—	(936)	104
Depreciation	342	332	302
Interest	218	243	189
	2,028	1,440	2,114
Other expense, net	33	—	—
Loss on sale of business	782	—	—
(Loss) income before income taxes and equity in net earnings of subsidiaries	(1,147)	481	(389)
(Benefit) provision for income taxes	(542)	61	(107)
(Loss) income before equity in net earnings of subsidiaries	(605)	420	(282)
Equity in net earnings of subsidiaries	2,277	2,028	896
Equity in net earnings of Kindred at Home	11	—	—
Net income	$ 1,683	$ 2,448	$ 614

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2018	2017	2016
	(in millions)		
Net income	$ 1,683	$ 2,448	$ 614
Other comprehensive income (loss):			
Change in gross unrealized investment losses/gains	(189)	149	(101)
Effect of income taxes	51	(55)	38
Total change in unrealized investment gains/losses, net of tax	(138)	94	(63)
Reclassification adjustment for net realized gains included in investment income	(53)	(14)	(96)
Effect of income taxes	17	5	35
Total reclassification adjustment, net of tax	(36)	(9)	(61)
Other comprehensive (loss) income, net of tax	(174)	85	(124)
Comprehensive income attributable to our equity method investment in Kindred at Home	(4)	—	—
Comprehensive income	$ 1,505	$ 2,533	$ 490

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2018	**2017**	**2016**
	(in millions)		
Net cash provided by operating activities	$ 2,719	$ 2,423	$ 1,848
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(354)	—	—
Acquisitions, equity method investment in Kindred at Home	(1,095)	—	—
Capital contributions to operating subsidiaries	(697)	(695)	(895)
Purchases of investment securities	(145)	(53)	(151)
Proceeds from sale of investment securities	35	—	25
Maturities of investment securities	59	51	143
Purchases of property and equipment, net	(465)	(359)	(382)
Net cash used in investing activities	(2,662)	(1,056)	(1,260)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	—	1,779	—
Proceeds from issuance (repayments) of commercial paper, net	485	(153)	(2)
Proceeds from term loan	1,000	—	—
Repayment of term loan	(350)	—	—
Repayment of long-term debt	—	(800)	—
Change in book overdraft	(3)	3	5
Common stock repurchases	(1,090)	(3,365)	(104)
Dividends paid	(265)	(220)	(177)
Proceeds from stock option exercises and other	48	62	11
Net cash used in financing activities	(175)	(2,694)	(267)
(Decrease) increase in cash and cash equivalents	(118)	(1,327)	321
Cash and cash equivalents at beginning of year	383	1,710	1,389
Cash and cash equivalents at end of year	$ 265	$ 383	$ 1,710

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $2.3 billion in 2018, $1.4 billion in 2017, and $0.8 billion in 2016.

Guarantee

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

3. REGULATORY REQUIREMENTS

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $7.6 billion and $8.0 billion as of December 31, 2018 and 2017, respectively, which exceeded aggregate minimum regulatory requirements of $5.2 billion and $4.8 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2019 is approximately $1 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $2.3 billion in 2018, $1.4 billion in 2017, and $0.8 billion in 2016.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. During 2018, 2017 and 2016, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 11 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 15 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2018, 2017, and 2016
(in millions)

	Balance at Beginning of Period	Acquired/(Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2018	$ 96	$ —	$ 36	$ (29)	$ (24)	$ 79
2017	118	—	20	(10)	(32)	96
2016	101	—	39	19	(41)	118
Deferred tax asset valuation allowance:						
2018	(49)	—	(5)	—	—	(54)
2017	(49)	—	—	—	—	(49)
2016	(42)	—	(7)	—	—	(49)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE

Brian A. Kane

Chief Financial Officer
(Principal Financial Officer)

Date: February 21, 2019

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Chief Financial Officer (Principal Financial Officer)	February 21, 2019
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 21, 2019
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 21, 2019
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 21, 2019
/s/ FRANK BISIGNANO **Frank Bisignano**	Director	February 21, 2019
/s/ KAREN DESALVO MD, MPH, MSc **Karen DeSalvo, MD, MPH, MSc**	Director	February 21, 2019
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 21, 2019
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 21, 2019
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 21, 2019
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 21, 2019
/s/ WILLIAM E. MITCHELL **William E. Mitchell**	Director	February 21, 2019
/s/ DAVID B. NASH, M.D. **David B. Nash, M.D.**	Director	February 21, 2019
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 21, 2019
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 21, 2019

Exhibit 10(aa)

HUMANA INC.

CHANGE IN CONTROL POLICY

This Humana Inc. Change in Control Policy (this "Policy") has been adopted by the Organization & Compensation Committee (the "Committee") of the Board of Directors of the Company to avoid the departure of and provide protection to Executives in the event of a Change in Control in order that they may act in the best interest of all shareholders and to reinforce and encourage their continued attention and dedication to their duties without the distraction and concern for the uncertainty that would result from the effects a Change in Control would have on their personal situations. This Policy shall be effective as of the Effective Date as provided herein, and shall apply to all Executives (as defined herein).

Section 1. Definitions. For purposes of this Policy, the following terms shall have the following meaning:

"Annual Base Salary" shall mean an Executive's stated annual compensation without regard to any bonus, perquisite or other benefits.

"Board" means the Board of Directors of the Company.

"Cause" shall mean a termination by reason of the conviction of Executive, by a court of competent jurisdiction and following the exhaustion of all possible appeals, of a criminal act involving the Company or its assets.

"CEO" shall mean the Company's President and Chief Executive Officer.

"CEO Direct Reports" shall mean Executive Officers of the Company who are direct reports to the Company's President and Chief Executive Officer.

"Change in Control" shall have the meaning set forth in Exhibit A.

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"Company" means Humana Inc., a Delaware corporation, and any successor thereto.

"Compensation Committee" means the Organization and Compensation Committee of the Board.

"Date of Termination" shall mean the date specified in the Notice of Termination, not to exceed thirty (30) days from the date such Notice of Termination is given, or as otherwise agreed to by Executive and the Company.

"**Executive**" shall mean all eligible employees, which includes the CEO Direct Reports, other Executive Officers, and such other individuals as identified by the Compensation Committee who do not have separate agreements or arrangements that provide for payments and/or benefits upon a Change in Control (other than equity related agreements or arrangements).

"**Executive Officer**" shall include those executive officers designated by the Board under Rule 16a-1(f) under the Securities Exchange Act of 1934, as amended.

"**Good Reason**" shall mean the occurrence after a Change in Control of any of the following events without Executive's express written consent:

(i) Any material reduction in Executive's title, authority or responsibilities, including reporting responsibilities;

(ii) A reduction by the Company in Executive's Annual Base Salary as in effect on the date of the Change in Control or as the same may be increased from time to time;

(iii) The relocation of Executive's office at which Executive is to perform his or her duties to a location more than thirty (30) miles from the location at which Executive performed his or her duties prior to the Change in Control;

(iv) The failure by the Company to continue in effect any incentive, bonus or other compensation plan in which Executive participates, unless the Company substitutes a substantially equivalent benefit;

(v) The failure by the Company to continue in effect any Executive benefit plan (including any medical, hospitalization, life insurance, dental or disability benefit plan in which Executive participated) or any material fringe benefit or perquisite enjoyed by Executive at the time of the Change in Control, unless the Company substitutes benefits which, in the aggregate, are equivalent; or

(vi) The failure of the Company to obtain a satisfactory agreement from any successor or assign of the Company to assume and agree to perform this Policy.

A termination of employment by the Executive for Good Reason shall only be effectuated after giving the Company written notice of the termination, setting forth the conduct of the Company that constitutes Good Reason, within 30 days of the first date on which the Executive has knowledge of such conduct. The Executive shall further provide the Company with at least 30 days following the date on which such written notice is provided to cure such conduct. If the Company fails to cure such conduct, a termination of employment by the Executive for Good Reason shall be effective on the day following the expiration of such 30-day cure period.

"**Effective Date**" means March 1, 2019, which is the date that this Policy is effective.

"Exchange Act" means the Securities Exchange Act of 1934, and any successor statute, as it may be amended from time to time.

"Notice of Termination" shall mean a notice which shall indicate the specific termination provision in this Policy which is relied upon and shall set forth in reasonable detail the facts and circumstances claimed to provide a basis for termination of Executive's employment under the provision so indicated. Any purported termination by the Company or by Executive hereunder shall not be effective until communicated by written Notice of Termination to the other party.

"Payments" means any payment or distribution of any type to Executive or for Executive's benefit by the Company, any affiliate of the Company, any Person who acquires ownership or effective control of the Company or ownership of a substantial portion of the Company's assets (within the meaning of Section 280G of the Code and the regulations thereunder), or any affiliate of such Person, whether paid or payable or distributed or distributable pursuant to the terms of this Policy or otherwise.

"Person" means any individual, corporation, partnership, limited liability company, association, trust or other entity or organization, including a government or political subdivision or an agency or instrumentality thereof.

"Qualifying Termination" means (i) by the Company other than for Cause, or by Executive for Good Reason within twenty-four (24) months following a Change in Control and during the term of this Policy, or (ii) by the Company other than for Cause at any time prior to the date of a Change in Control and such termination occurred after the Company entered into a definitive agreement, the consummation of which would constitute a Change in Control.

"Section 409A" shall mean Section 409A of the Code.

"Separation from Service" means a termination of the employment relationship of Executive with the Company or an affiliate within the meaning of Section 409A and Treasury Regulation section 1.409A-1(h) or any successor thereto.

"Severance Multiple" means (i) for the CEO, two and a half (2.5) times, (ii) for CEO Direct Reports, two (2) times, and (iii) for other Executives, no greater than one and a half (1.5) times.

"Severance Period" means (i) for the CEO, thirty (30) months, (ii) for CEO Direct Reports, twenty-four (24) months, and (iii) for other Executives, no greater than eighteen (18) months or such other period as the Committee shall determine.

"Severance Rate" means an amount equal to the sum of (A) Executive's Annual Base Salary at the greater of the rate in effect at the time the Change in Control occurred, if applicable, or when the Notice of Termination was given plus (B) the target annual bonus or incentive compensation which could have been earned by Executive (including, but not limited to, any target sales incentive compensation, to the extent applicable) calculated as if all relevant goals had been met during the then-current fiscal year of the Company pursuant to the terms of the incentive compensation plan in which Executive participates. With respect to clause (B), If there

is no incentive compensation plan in effect at the time the Notice of Termination is given, then for purposes of clause (B) hereof it shall be assumed that the amount of incentive compensation to be paid to Executive shall be the target amount under any incentive compensation plan in which Executive participated at the date of the Change in Control, if applicable, or the most recent plan participated in, whichever would be greater.

Section 2. Benefits.

(a) In the event of a Qualifying Termination, subject to Sections 3(d), 4 and 5 hereof, the Company shall pay to Executive in a lump sum within fifteen (15) business days after the Date of Termination:

(i) Executive's base salary earned but not yet paid through the Date of Termination at the greater of the rate in effect at the time the Change in Control occurred, if applicable, or when the Notice of Termination was given, plus any bonuses or incentive compensation which, pursuant to the terms of any compensation or benefit plan, have been earned and are payable as of the Date of Termination, but have not actually been paid by the Date of Termination. For purposes of this Policy, bonuses and incentive compensation shall be considered payable if all conditions for earning them have been met and any requirement that Executive be actively employed as of the date of payment shall be disregarded;

(ii) A lump sum in an amount equal to (x) the applicable Severance Multiple for such Executive multiplied by (y) the Severance Rate.

(b) In addition, in the event of a Qualifying Termination the Company shall, for the period stated below, maintain in full force and effect for the benefit of Executive and Executive's dependents and beneficiaries, at the Company's expense, all life insurance, health insurance, dental insurance, accidental death and dismemberment insurance and disability insurance under plans and programs in which Executive and/or Executive's dependents and beneficiaries participated immediately prior to the Consummation of the Change in Control, provided that continued participation is possible under the general terms and provisions of such plans and programs (the "Extended Benefits"). The Extended Benefits shall be continued until the earlier of (A) the end of the applicable Severance Period for such Executive, and (B) the effective date of Executive's coverage under equivalent benefits from a new employer (provided that no such equivalent benefits shall be considered effective unless and until all pre-existing condition limitations and waiting period restrictions have been waived or have otherwise lapsed). If participation in any such plan or program is barred, the Company shall arrange at its own expense to provide Executive with benefits substantially similar to those which Executive would have been entitled to receive under such plans and programs. At the end of the period of coverage, Executive shall have the right to have assigned to him or her, at no cost and with no apportionment of prepaid premiums, any assignable insurance policy relating specifically to him or her. At the conclusion of the coverage provided under this Section 3(b), Executive shall be entitled to the continuation for a period of 18 months of the health and dental insurance then being provided to him or her at a cost to him or her equal to the amount then being charged to employees of the Company for such coverage provided pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA). The coverage provided pursuant to this Subsection shall be in satisfaction of the Company's

obligation to provide coverage under COBRA. The Company will use all commercially reasonable efforts to provide for the continuation of benefits in a manner that (A) does not subject the benefits to Section 409A and (B) does not cause the benefits to be included in the taxable income of Executive.

(c) In addition, upon a Qualifying Termination of employment, the Company will (i) provide an Executive who is the CEO or a CEO Direct Report with financial planning services during the one year period immediately following the Date of Termination on the same terms as the financial planning services were provided to such Executive immediately prior to the Change in Control and (ii) provide eligible individuals with outplacement services through an outplacement firm of the Company's choosing at a level of services to be determined by the Company, with such services to extend until the earlier of (A) twelve months following the Date of Termination for the CEO or CEO Direct Reports, or six months following the Date of Termination for other Executives, or (B) the date Executive secures full time employment.

(d) Benefits under this Policy shall not be duplicative of, and shall be offset by, the same type of benefit payable under an agreement between the Company and Executive or another plan, program or arrangement of the Company covering Executive. To the extent that benefits under this Policy are the same type of benefit payable under such agreement or plan, program or arrangement which is subject to, and not exempt from, the requirements of Section 409A, then the benefits payable under this Policy shall be payable at the same time and in the same form as the benefits payable under such agreement or plan, program or arrangement, but only to the extent that such other benefits are subject to and not exempt from Section 409A.

Section 3. 280G Considerations. Notwithstanding anything to the contrary contained in this Policy, (a) to the extent that any Payments constitute "parachute payments" (within the meaning of Section 280G of the Code), and if (b) such aggregate Payments would, if reduced by all federal, state and local taxes applicable thereto (including the excise tax imposed under Section 4999 of the Code (the "Excise Tax")), be less than the amount that Executive would receive, after all taxes, if Executive received aggregate Payments equal (as valued under Section 280G of the Code) to only three times Executive's "base amount" (within the meaning of Section 280G of the Code), less $1.00, then (c) such Payments will be reduced (but not below zero) if and to the extent necessary so that no Payments to be made or benefit to be provided to Executive will be subject to the Excise Tax. All determinations required to be made pursuant to this letter agreement will be made by a nationally recognized accounting firm selected by the Company (the "Accounting Firm"), which will provide detailed supporting calculations (which will include specific information about each Payment (including the amount of each Payment)). For purposes of making the calculations required by this Section 4, the Accounting Firm may make reasonable assumptions and approximations concerning applicable taxes and may rely on reasonable, good faith interpretations concerning the application of Sections 280G and 4999 of the Code. Executive and the Company will furnish to the Accounting Firm such information and documents as the Accounting Firm may reasonably request in order to make a determination under this letter agreement. The Company will bear all costs and make all payments for the Accounting Firm's services relating to any calculations contemplated by this Section 4 and any such determination by the Accounting Firm will be binding upon Executive and the Company. If a determination is made to reduce the Payments, the Company will reduce or eliminate the Payments (i) by first reducing or eliminating the portion of the Payments relating to the provision of outplacement services, (ii)

then by reducing or eliminating cash payments (other than cash payments that are subject to clause (iv) hereof), (iii) then by reducing or eliminating the portion of the Payments which are not payable in cash and are attributable to equity awards (other than that portion of such Payments that are subject to clause (iv) hereof), and (iv) then by reducing or eliminating the portion of the Payments (whether payable in cash or not payable in cash) to which Treasury Regulation § 1.280G-1 Q/A 24(c) applies, in each case in reverse order beginning with payments or benefits which are to be paid the latest in time. It is possible that, after the determinations and selections pursuant to this letter agreement are made, Executive will receive Payments that are, in the aggregate, either more or less than the amount that should have been provided (hereafter referred to as an "Excess Payment" or "Underpayment," respectively). If it is established, pursuant to a final determination of a court or an Internal Revenue Service proceeding that has been finally and conclusively resolved, that an Excess Payment has been made, then Executive will promptly pay an amount equal to the Excess Payment to the Company. In the event that it is determined (i) by a final determination of a court or (ii) by the Accounting Firm upon request by either Executive or the Company, that an Underpayment has occurred, the Company will promptly pay an amount equal to the Underpayment to Executive.

Section 4. Restrictive Covenants. In consideration of Executive's employment by the Company and the rights and benefits of Executive provided by this Policy, Executive will enter into agreements that contain certain covenants regarding non-competition, non-solicitation, non-disparagement and specific enforcement with the restricted period for the non-competition and non-solicitation covenants to be the applicable Severance Period for such Executive, commencing upon the Date of Termination, with such covenants to be substantially in the form attached as Exhibit B hereto.

Section 5. Administration. The Compensation Committee is responsible for the administration of this Policy and shall have all powers and duties necessary to fulfill its responsibilities. The Compensation Committee shall determine any and all questions of fact, resolve all questions of interpretation of the Policy which may arise, and exercise all other powers and discretion necessary to be exercised under the terms of the Policy which it is herein given or for which no contrary provision is made. The Compensation Committee shall have full power and discretion to interpret the Policy and related documents, to resolve ambiguities, inconsistencies and omissions, to determine any question of fact, and to determine the rights and benefits, if any, of any Executive or other employee, in accordance with the provisions of the Policy. The Compensation Committee's decision with respect to any matter shall be final and binding on all parties concerned. The validity of any such interpretation, construction, decision, or finding of fact shall not be given de novo review if challenged in court, by arbitration, or in any other forum, and shall be upheld unless clearly arbitrary or capricious. The Compensation Committee may, from time to time, by action of its appropriate officers, delegate to designated persons or entities the right to exercise any of its powers or the obligation to carry out its duties under the Policy.

Section 6. Section 409A

(a) Compliance. To the extent applicable, it is intended that this Policy comply with the provisions of Section 409A, so as to prevent inclusion in gross income of any amounts payable or benefits provided hereunder in a taxable year that is prior to the taxable year or years in which such amounts or benefits would otherwise actually be distributed, provided or

otherwise made available to Executive. This Policy shall be construed, administered, and governed in a manner consistent with this intent. If and to the extent that any payment or benefit under this Policy is determined by the Company to constitute "non-qualified deferred compensation" subject to Section 409A and is payable to Executive by reason of Executive's termination of employment, then such payment or benefit shall be made or provided to Executive only upon a Separation from Service as defined for purposes of Section 409A. Each severance payment under this Policy will be considered a "separate payment" and not one of a series of payments for purposes of Section 409A. To the extent that any benefits to be provided to Executive pursuant to this Policy are considered nonqualified deferred compensation and are reimbursements subject to Treasury Regulation Section 1.409A-3(i)(1)(iv), then (i) the reimbursement of eligible expenses related to such benefits shall be made on or before the last day of Executive's taxable year following Executive's taxable year in which the expense was incurred and (ii) notwithstanding anything to the contrary in this Policy or any plan providing for such benefits, the amount of expenses eligible for reimbursement during any taxable year of Executive shall not affect the expenses eligible for reimbursement in any other taxable year. Nothing in this Policy will provide a basis for any person to take action against the Company or its affiliates based on matters covered by Section 409A and in no event will the Company or its affiliates be liable for any additional tax, interest or penalties that may be imposed on Executive under Section 409A or any damages for failing to comply with Section 409A.

(b) Six Month Delay for Specified Executives. To the extent that any amount payable or benefit to be provided under this Policy constitutes a nonexempt "nonqualified deferred compensation plan" (as defined in Section 409A) upon a Separation from Service, and to the extent an Executive is deemed to be a "specified employee" (as that term is defined in Section 409A and pursuant to procedures established by the Company) on the Date of Termination, notwithstanding any other provision in this Policy to the contrary, such payment or benefit provision will not be made to Executive during the six month period immediately following the Date of Termination. Instead, on the first business day of the seventh month following the Date of Termination, all amounts that otherwise would have been paid or provided to Executive during the six month period, but were not paid or provided because of this Section 7(b), will be paid or provided to Executive at such time without interest. This six month delay will cease to be applicable if Executive incurs a Separation from Service due to death or if Executive dies before the six month period has expired.

Section 7. Amendment and Termination.

(a) This Policy may be amended by the Compensation Committee at any time, or the Compensation Committee may determine at any time that any Executive is no longer eligible to receive benefits under this Policy; provided, however, that any such amendment or determination of eligibility that would adversely affect an Executive will not be applicable without such Executive's consent until the later of (i) one year following the date of such amendment, and (ii) two years following consummation of a transaction that constitutes a Change of Control if a definitive agreement pertaining to such transaction was entered into prior to the date of such amendment.

(b) This Policy shall continue indefinitely after the Effective Date, unless the Compensation Committee shall decide to terminate this Policy by adopting resolutions

terminating this Policy; provided, however, that any such termination of the Policy shall (i) not be effective until the first anniversary after the action to terminate the Policy is taken by the Compensation Committee and (ii) not affect any payments or benefits already owed to Executive pursuant to the terms of the Policy at the time the termination of the Policy becomes effective.

Section 8. Miscellaneous.

(a) The Company shall pay all reasonable legal fees and related expenses (including the costs of experts, evidence and counsel) incurred by Executive as a result of Executive seeking to obtain or enforce any right or benefit provided by this Policy, provided the Executive is successful on at least one material claim to obtain or enforce such rights or benefits. The reimbursement of the eligible expense must be made on or before the last day of Executive's taxable year following Executive's taxable year in which it was determined that such expense was incurred reimbursable.

(b) This Policy shall be binding upon any successor in interest of the Company or an affiliate (whether direct or indirect, by purchase, merger, consolidation or otherwise) to all or substantially all of the business or assets of the Company, and shall be enforceable by or on behalf of an Executive in the same manner and to the same extent as the Company is bound and as if no succession had taken place. As used in this Policy, the term "Company" shall include any successor to all or substantially all its business or assets or which becomes bound by the terms of this Policy by the terms hereof, by operation of law, or otherwise. It is intended that this Policy confer vested and nonforfeitable rights for each Executive to receive benefits to which Executive is entitled under the terms of this Policy with Executives being third party beneficiaries.

(c) Except as otherwise provided herein, this Policy shall not affect any Executive's rights or entitlement to other accrued but unpaid compensation or benefits under any other employee benefit program offered to Executive by the Company or an affiliate as of the Date of Termination.

(d) The various provisions of this Policy are severable and any determination of invalidity or unenforceability of any one provision shall not have any effect on the remaining provisions.

(e) For the purposes of this Policy, notices and all other communications provided for in the Policy shall be in writing and shall be deemed to have been duly given when personally delivered or sent by electronic mail or certified mail, return receipt requested, postage prepaid, addressed to the respective addresses last given by each party to the other, provided that all notices to the Company shall be directed to the attention of the Chief Human Resources Officer and Corporate Secretary of the Company. All notices and communications shall be deemed to have been received on the date of delivery thereof or on the third business day after the mailing thereof, except that notice of change of address shall be effective only upon receipt.

(f) Executive shall not be required to mitigate the amount of any payment provided under this Policy by seeking other employment or otherwise, nor shall the

amount of any payment provided under this Policy be reduced by any earnings of Executive after the Date of Termination from any subsequent employer or from any other source.

(g) All payments made pursuant to this Policy shall be subject to withholding of required income and employment taxes.

(h) This Policy shall be governed by and construed in accordance with the internal laws of the State of Kentucky.

Exhibit A

"Change in Control" shall mean the occurrence of:

1) An acquisition (other than directly from the Company) of any voting securities of the Company (the "Voting Securities") by any "Person" (as the term person is used for purposes of Section 13(d) or 14(d) of the Exchange Act), immediately after which such Person has "Beneficial Ownership" (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of twenty percent (20%) or more of the combined voting power of the Company's then outstanding Voting Securities; provided, however, in determining whether a Change in Control has occurred, Voting Securities which are acquired in a "Non-Control Acquisition" (as hereinafter defined) shall not constitute an acquisition which would cause a Change in Control. A "Non-Control Acquisition" shall mean an acquisition by (i) an employee benefit plan (or a trust forming a part thereof) maintained by (A) the Company or (B) any corporation or other Person of which a majority of its voting power or its equity securities or equity interest is owned, directly or indirectly, by the Company (for purposes of this definition, a "Subsidiary") (ii) the Company or its Subsidiaries, or (iii) any Person in connection with a "Non-Control Transaction" (as hereinafter defined);

2) The individuals who, as of the Effective Date are members of the Board (the "Incumbent Board"), cease for any reason to constitute at least two-thirds of the members of the Board; provided, however, that if the election, or nomination for election by the Company's common stockholders, of any new director was approved by a vote of at least two-thirds of the Incumbent Board, such new director shall, for purposes of this Policy, be considered as a member of the Incumbent Board; provided further, however, that no individual shall be considered a member of the Incumbent Board if such individual initially assumed office as a result of either an actual or threatened solicitation of proxies or consents by or on behalf of a Person other than the Board (a "Proxy Contest") including by reason of any agreement intended to avoid or settle any Proxy Contest; or

3) The consummation of:

   a) A merger, consolidation or reorganization involving the Company, unless such merger, consolidation or reorganization is a "Non-Control Transaction." A "Non-Control Transaction" shall mean a merger, consolidation or reorganization of the Company where:

      i) the stockholders of the Company, immediately before such merger, consolidation or reorganization, own directly or indirectly immediately following such merger, consolidation or reorganization, at least seventy-five percent (75%) of the combined voting power of the outstanding Voting Securities of the corporation resulting from such merger or consolidation or reorganization (the "Surviving Corporation") in substantially the same proportion as their ownership of the Voting Securities immediately before such merger, consolidation or reorganization;

      ii) the individuals who were members of the Incumbent Board immediately prior to the execution of the agreement providing for such merger, consolidation or reorganization constitute at least two-thirds of the members of the board of directors of the Surviving

Corporation, or a corporation beneficially directly or indirectly owning a majority of the Voting Securities of the Surviving Corporation, and no agreement, plan or arrangement is in place to change the composition of the board of directors following the merger, consolidation or reorganization; and

iii) no Person other than (i) the Company, (ii) any Subsidiary, (iii) any employee benefit plan (or any trust forming a part thereof) maintained by the Company, the Surviving Corporation, or any Subsidiary, or (iv) any Person who, immediately prior to such merger, consolidation or reorganization had Beneficial Ownership of twenty percent (20%) or more of the then outstanding Voting Securities, has Beneficial Ownership of twenty percent (20%) or more of the combined voting power of the Surviving Corporation's then outstanding voting securities.

b) A complete liquidation or dissolution of the Company; or

c) The sale or other disposition of all or substantially all of the assets of the Company to any Person (other than a transfer to a Subsidiary).

Notwithstanding the foregoing, a Change in Control shall not be deemed to occur solely because any Person (the "Subject Person") acquired Beneficial Ownership of more than the permitted amount of the then outstanding Voting Securities as a result of the acquisition of Voting Securities by the Company which, by reducing the number of Voting Securities then outstanding, increases the proportional number of Shares Beneficially Owned by the Subject Persons, provided that if a Change in Control would occur (but for the operation of this sentence) as a result of the acquisition of Voting Securities by the Company, and after such share acquisition by the Company, the Subject Person becomes the Beneficial Owner of any additional Voting Securities which increases the percentage of the then outstanding Voting Securities Beneficially Owned by the Subject Person, then a Change in Control shall occur.

It is the intent of the Company that, with respect to any amount payable or benefit to be provided under this Policy that is subject to, and not exempt from Section 409A, the definition of "Change in Control" satisfies, and be interpreted in a manner that satisfies, the applicable requirements of Section 409A. If the definition of "Change in Control" would otherwise frustrate or conflict with the intent expressed above, that definition to the extent possible shall be interpreted and deemed amended so as to avoid such conflict.

Exhibit B

Restrictive Covenants

Confidential Information and Trade Secrets

The Executive recognizes that the Executive's position with the Company requires considerable responsibility and trust, and, in reliance on the Executive's loyalty, the Company may entrust the Executive with highly sensitive confidential, restricted and proprietary information involving Trade Secrets and Confidential Information.

"Trade Secret" shall be defined as any scientific or technical information, design, process, procedure, formula or improvement that is valuable and not generally known to competitors of the Company. "Confidential Information" is any data or information, other than Trade Secrets, that is important, competitively sensitive, and not generally known by the public, including, but not limited to, the Company's business plans, business prospects, training manuals, product development plans, bidding and pricing procedures, market strategies, internal performance statistics, financial data, confidential personnel information concerning employees of the Company, supplier data, operational or administrative plans, policy manuals, and terms and conditions of contracts and agreements. The terms "Trade Secrets" and "Confidential Information" shall not apply to information which is (i) already in the Executive's possession (unless such information was used in connection with formulating the Company's business plans, obtained by the Executive from the Company or was obtained by the Executive in the course of the Executive's employment by the Company), or (ii) required to be disclosed by any applicable law.

Except as may be required by law or legal process or an order of a court of competent jurisdiction, the Executive will not use or disclose any Trade Secrets or Confidential Information of the Company at any time after termination of employment and prior to such time as they cease to be Trade Secrets or Confidential Information through no act of the Executive in violation of this Section.

Executive will surrender to the Company all memoranda, notes, records, plans, manuals or other documents pertaining to the Company's business or the Executive's employment (including all copies thereof). The Executive will also leave with the Company all materials involving Trade Secrets or Confidential Information of the Company. All such information and materials, whether or not made or developed by the Executive, shall be the sole and exclusive property of the Company, and the Executive hereby assigns to the Company all of the Executive's right, title and interest in and to any and all of such information and materials.

Agreement Not to Compete and Agreement Not to Solicit

The Executive hereby covenants and agrees that during the Severance Period the Executive, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, stockholder, investor or principal of, or consultant or independent contractor with, another entity, shall not participate in any business which competes with the Company including, without limitation, health maintenance organizations, insurance companies or prepaid health plan businesses in which the Company has been actively engaged during any part of the two (2) year period immediately preceding the Executive's employment Termination Date ("Company

Business"), in any Geographic Area (as defined below) in which the Company and/or any of its Affiliates is then doing business. For purposes of this Policy, "Geographic Area" means any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

The Executive hereby covenants and agrees that during the Severance Period, the Executive, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, stockholder, investor or principal of, or consultant or independent contractor with, another entity, shall not: (1) interfere with the relationship of the Company and any of its employees, agents, representatives, consultants or advisors; (2) divert, or attempt to cause the diversion from the Company, any Company Business, nor interfere with relationships of the Company with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers; or (3) solicit, recruit or otherwise induce or influence any employee of the Company to accept employment in any business which competes with the Company Business, in any Geographic Area in which the Company and/or any of its Affiliates is then doing business.

Exhibit 10(f)

HUMANA INC.

EXECUTIVE SEVERANCE POLICY

This Humana Inc. Executive Severance Policy has been adopted by the Organization & Compensation Committee (the "Committee") of the Board of Directors of the Company to apply to selected executive employees of the Company. Executives will be eligible for coverage under the Policy for the payment of severance benefits upon termination of employment under certain circumstances, subject to the conditions set forth below. This Policy shall be effective as of the Effective Date as provided herein.

1. Definitions. For purposes of this Policy, the following terms shall have the following meaning:

"Annual Base Salary" shall mean an Executive's stated annual compensation without regard to any bonus, perquisite or other benefits.

"Annual Bonus" means the annual bonus or incentive compensation payable to Executive under the Company's annual bonus or incentive compensation program in which Executive participates from time to time.

"Cause" means (i) a felony conviction of Executive, (ii) the failure of Executive to contest prosecution for a felony, or (iii) Executive's willful misconduct or dishonesty, any of which is determined by the Compensation Committee to be directly and materially harmful to the business or reputation of the Company or any of its subsidiaries.

"CEO" shall mean the Company's President and Chief Executive Officer.

" CEO Direct Reports" shall mean Executive Officers of the Company who are direct reports to the Company's President and Chief Executive Officer.

"Company" means Humana Inc., a Delaware corporation.

"Code" means the Internal Revenue Code of 1986, as amended.

"Compensation Committee" means the Organization and Compensation Committee of the Board of Directors of the Company.

"Date of Termination" means the effective date of the relevant Executive's termination of employment with the Company.

"Effective Date" means March 1, 2019, or such later date as determined by the Compensation Committee with respect to an Executive.

"Executive" means Executive Officers of the Company (including the CEO) and such other individuals as identified by the Compensation Committee, in each case employed by

the Company or an affiliate of the Company on a full-time or part-time basis. Individuals will continue to be deemed an "Executive" eligible for the rights and benefits under this Policy for a period of twelve (12) months following a change in role or title at the Company that would otherwise have caused the individual to cease to be an eligible Executive Officer or other individual identified by the Compensation Committee as eligible.

"Executive Officer" shall include those executive officers designated by the Board under Rule 16a-1(f) under the Securities Exchange Act of 1934, as amended.

"Policy" means this Humana Inc. Executive Severance Policy.

" Separation from Service" means a termination of the employment relationship of the Executive with the Company or an affiliate within the meaning of Section 409A of the Code and Treasury Regulation section 1.409A-1(h) or any successor thereto.

"Severance Period" means (i) for the CEO, twenty-four (24) months following the Date of Termination, (ii) for CEO Direct Reports, eighteen (18) months following the Date of Termination and (iii) for all other Executives, six (6) months plus two (2) weeks per year of completed service.

"Severance Rate" means (i) for the CEO, the CEO's then current Annual Base Salary plus the target annual bonus or incentive compensation which could have been earned by the CEO, calculated as if all relevant goals had been met during the Company's then-current fiscal year pursuant to the terms of the incentive compensation plan in which the CEO participates, and (ii) for all of Executives, such Executive's then current Annual Base Salary.

2. Term of Policy. The term of this Policy shall begin on the Effective Date and shall continue in effect until modified or terminated by the Company pursuant to Section 13 hereof.

3. Termination. The Company may terminate the employment of Executive for any reason and at any time. In the event that the Company terminates the employment of Executive without Cause, Executive shall be entitled to the following rights and benefits under this Section 3:

3.1 Severance Benefits. Subject to Executive's compliance with all terms of this Policy, including, without limitation, Sections 5 and 6 hereof:

(i) Salary Continuation Payments. The Company will pay Executive salary continuation through the Severance Period at an annual rate equal to such Executive's Severance Rate; provided that any payments that would otherwise be paid during the Severance Period that remain outstanding as of March 15 of the year following the year during which the Date of Termination occurred shall be paid in a lump sum on such date. Salary continuation under this Section 3.1 shall be paid on a bi-weekly basis in accordance with the Company's customary payroll practices with the first payment to be made in accordance with Section 5 hereof, subject to the accelerated payment of the remaining amounts in accordance with the prior sentence.

(ii) Pro-Rata Bonus. The Company will pay Executive an amount equal to the product of (A) the Annual Bonus, if any, that Executive would have earned for the calendar year in which the Date of Termination occurs, based on achievement of the applicable performance

goals for each such calendar year, as uniformly applied to other Executives who remain employed through the end of the applicable performance period and (B) a fraction, the numerator of which is the number of days Executive was employed by the Company during the calendar year of termination, and the denominator of which is the number of days in such calendar year. This amount shall be paid on the date that Annual Bonuses are normally paid, but in no event later than March 15th of the year following the year in which the Date of Termination occurs.

(iii) Continued Health Benefit Coverage. The Company will provide to each Executive and Executive's eligible dependents, through the end of the (i) applicable Severance Period for such Executive, or (ii) the effective date of Executive's coverage under equivalent benefits from a new employer (provided that no such equivalent benefits shall be considered effective unless and until all pre-existing condition limitations and waiting period restrictions have been waived or have otherwise lapsed), at the Compensation Committee's option, either (A) continued medical and dental coverage under the Company's health care plan at the same level of coverage to which such Executive was entitled on the Date of Termination, subject to eligibility requirements and other conditions contained in the plan, including the requirement that Executive continue to pay the "employee portion" of the cost thereof, or (B) equivalent benefits (or equivalent cash value, payable on an after-tax basis), as determined in the sole reasonable discretion of the Compensation Committee. The coverage provided pursuant to this Section 3.1(iii) shall be in satisfaction of the Company's obligation to provide coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

(iv) Outplacement Services; Financial Planning. The Company will provide an Executive who is the CEO or a CEO Direct Report or otherwise designated by the Committee (i) with financial planning services during the one year period immediately following the Date of Termination on the same terms as the financial planning services were provided to such Executive immediately prior to the Date of Termination, and (ii) with outplacement services through an outplacement firm of the Company's choosing at a level of services to be determined by the Company, with such services to extend until the earlier of (A) one year following the Date of Termination or (B) the date Executive secures full time employment.

3.2 Accrued Rights. Within fifteen (15) business days following the Date of Termination, the Company will pay or provide Executive with (i) all accrued but unpaid base salary through the Date of Termination, (ii) vacation pay accrued but not used in accordance with the Company's vacation pay policy, (iii) any previously awarded but unpaid Annual Bonus for a completed calendar year prior to the Date of Termination, (iv) any unreimbursed business expenses that are reimbursable under the Company's business expense policy, and (v) all rights and benefits under the employee benefit plans of the Company in which Executive is then participating, (collectively, the "Accrued Rights").

3.3 No Additional Rights. Except as provided in this Section 3, Executive's participation under any benefit plan, program, policy or arrangement sponsored or maintained by the Company shall be treated in accordance with the terms of the applicable plan. Without limiting the generality of the foregoing, Executive's eligibility for and active participation in any of the retirement plans maintained by the Company will end on the Date of Termination and Executive will earn no additional benefits, including, without limitation, any additional service credit, under those plans after that date. Executive shall be treated as a terminated employee for purposes of all

such benefit plans and programs effective as of the Date of Termination, and shall receive all payments and benefits due under such plans and programs in accordance with the terms and conditions thereof.

4. Other Terminations. The Company may terminate the employment of Executive for any reason and at any time. In the event that the Company terminates the employment of Executive during the term of the Policy, other than a termination of employment by the Company for Cause, the Company will pay or provide Executive with all Accrued Rights. Executive may terminate his or her employment for any reason and at any time and shall not be entitled to any payments or benefits under this Policy by reason of such termination of employment from the Company. This Policy shall have no effect on the rights and benefits to which an Executive is entitled upon retirement under (without limitation) any retirement or savings plan of the Company, which shall be governed exclusively by the terms of such plans and agreements, as applicable.

5. Release.

5.1 As a condition precedent to receiving the payments and benefits as provided herein, Executive will execute (and not revoke) a general release of claims (the "Release"), in a form provided by the Company. If Executive fails to execute and deliver the Release, or revokes the Release, Executive agrees that he shall not be entitled to receive the payments and benefits described herein. For purposes of this Policy, the Release shall be considered to have been executed by Executive if it is signed by Executive's legal representative in the case of legal incompetence or on behalf of Executive's estate in the case of Executive's death.

5.2 Except as otherwise specified or agreed to by Executive and the Company, payment of any amounts described hereunder that are subject to the Release will begin on the 60th day following the Date of Termination, with the first such payment to include any amounts attributable to payroll intervals occurring prior to such date, provided, however, that, to the extent that the payments are exempt from Section 409A of the Code, such exempt payments shall be made beginning with the first payroll date following the effectiveness of the Release.

6. Restrictive Covenants. In consideration of Executive's employment by the Company and the rights and benefits of Executive provided by this Policy, Executive will enter into agreements that contain certain covenants regarding non-competition, non-solicitation, non-disparagement and specific enforcement with the restricted period for the non-competition and non-solicitation covenants to be the applicable Severance Period for such Executive, commencing upon the Date of Termination, with such covenants to be substantially in the form attached as Exhibit A hereto and effective as of the Effective Date hereof (the "Restrictive Covenants Effective Date").

7. Section 409A.

7.1 Compliance. It is intended that this Policy be exempt from the provisions of Section 409A of the Code and this Policy shall be construed, administered, and governed in a manner consistent with this intent. If and to the extent that any payment or benefit under this Policy is determined by the Company to constitute "non-qualified deferred compensation" subject to Section 409A of the Code and is payable to Executive by reason of Executive's termination of

employment, then such payment or benefit shall be made or provided to Executive only upon a Separation from Service as defined for purposes of Section 409A of the Code. Each severance payment under this Policy will be considered a "separate payment" and not one of a series of payments for purposes of Section 409A of the Code. To the extent that any benefits to be provided to Executive pursuant to this Policy are considered nonqualified deferred compensation and are reimbursements subject to Treasury Regulation Section 1.409A-3(i)(1)(iv), then (i) the reimbursement of eligible expenses related to such benefits shall be made on or before the last day of the Executive's taxable year following the Executive's taxable year in which the expense was incurred and (ii) notwithstanding anything to the contrary in this Policy or any plan providing for such benefits, the amount of expenses eligible for reimbursement during any taxable year of the Executive shall not affect the expenses eligible for reimbursement in any other taxable year. Nothing in this Policy will provide a basis for any person to take action against the Company or its affiliates based on matters covered by Section 409A of the Code and in no event will the Company or its affiliates be liable for any additional tax, interest or penalties that may be imposed on Executive under Section 409A of the Code or any damages for failing to comply with Section 409A of the Code.

7.2 Six Month Delay for Specified Executives. To the extent that any amount payable or benefit to be provided under this Policy constitutes a nonexempt "nonqualified deferred compensation plan" (as defined in Section 409A of the Code) upon a Separation from Service, and to the extent an Executive is deemed to be a "specified employee" (as that term is defined in Section 409A of the Code and pursuant to procedures established by the Company) on the Date of Termination, notwithstanding any other provision in this Policy to the contrary, such payment or benefit provision will not be made to the Executive during the six month period immediately following the Date of Termination. Instead, on the first day of the seventh month following the Date of Termination, all amounts that otherwise would have been paid or provided to the Executive during the six month period, but were not paid or provided because of this Section 7.2, will be paid or provided to the Executive at such time without interest. This six month delay will cease to be applicable if the Executive incurs a Separation from Service due to death or if the Executive dies before the six month period has expired.

8. Withholding Taxes. All compensation payable pursuant to this Policy shall be subject to reduction by all applicable withholding, social security and other federal, state and local taxes and deductions, and the Company shall be authorized to make all such withholdings to the extent it determines necessary under applicable law.

9. Acknowledgment. Executive acknowledges that this Policy does not constitute a contract of employment or impose on the Company any obligation to retain Executive as an employee and that this Policy does not prevent Executive from terminating employment at any time.

10. Non-Duplication of Benefits; CIC Policy. The severance benefit under this Policy is not intended to duplicate any other benefits provided by the Company in connection with the termination of an employee's employment, such as wage replacement benefits, pay-in-lieu-of-notice, severance pay, or similar benefits under any other benefit plans, severance programs, employment contracts, or applicable federal or state laws, such as the WARN Acts. Should such other benefits be payable, the severance benefit under this Policy will be reduced accordingly or,

alternatively, severance benefits previously paid under this Policy will be treated as having been paid to satisfy such other benefit obligations. In either case, the Company will determine how to apply this provision and may override other provisions in this Policy in doing so. In addition, and notwithstanding anything else provided herein, to the extent Executive is entitled to severance payments and benefits upon termination of employment pursuant to the Company's Change in Control Policy or any other change in control arrangements, this Policy will cease to apply and Executive's entitlement to severance benefits shall be governed solely by the Change in Control Policy.

11. Administration. The Compensation Committee is responsible for the administration of this Policy and shall have all powers and duties necessary to fulfill its responsibilities. The Compensation Committee shall determine any and all questions of fact, resolve all questions of interpretation of the Policy which may arise, and exercise all other powers and discretion necessary to be exercised under the terms of the Policy which it is herein given or for which no contrary provision is made. The Compensation Committee shall have full power and discretion to interpret the Policy and related documents, to resolve ambiguities, inconsistencies and omissions, to determine any question of fact, and to determine the rights and benefits, if any, of any Executive or other employee, in accordance with the provisions of the Policy. The Compensation Committee's decision with respect to any matter shall be final and binding on all parties concerned. The validity of any such interpretation, construction, decision, or finding of fact shall not be given de novo review if challenged in court, by arbitration, or in any other forum, and shall be upheld unless clearly arbitrary or capricious. The Compensation Committee may, from time to time, by action of its appropriate officers, delegate to designated persons or entities the right to exercise any of its powers or the obligation to carry out its duties under the Policy.

12. Amendment and Termination. The Company reserves the right to amend or terminate this Policy at any time and in any manner, without consent or advance notice to Executives or other employees. No amendment or termination of the Policy shall affect the rights of an Executive whose Date of Termination has occurred prior to the date of such amendment or termination of the Policy and who remains entitled to severance payments or benefits under this Policy.

Exhibit A

Restrictive Covenants

Confidential Information and Trade Secrets

The Executive recognizes that the Executive's position with the Company requires considerable responsibility and trust, and, in reliance on the Executive's loyalty, the Company may entrust the Executive with highly sensitive confidential, restricted and proprietary information involving Trade Secrets and Confidential Information.

"Trade Secret" shall be defined as any scientific or technical information, design, process, procedure, formula or improvement that is valuable and not generally known to competitors of the Company. "Confidential Information" is any data or information, other than Trade Secrets, that is important, competitively sensitive, and not generally known by the public, including, but not limited to, the Company's business plans, business prospects, training manuals, product development plans, bidding and pricing procedures, market strategies, internal performance statistics, financial data, confidential personnel information concerning employees of the Company, supplier data, operational or administrative plans, policy manuals, and terms and conditions of contracts and agreements. The terms "Trade Secrets" and "Confidential Information" shall not apply to information which is (i) already in the Executive's possession (unless such information was used in connection with formulating the Company's business plans, obtained by the Executive from the Company or was obtained by the Executive in the course of the Executive's employment by the Company), or (ii) required to be disclosed by any applicable law.

Except as may be required by law or legal process or an order of a court of competent jurisdiction, the Executive will not use or disclose any Trade Secrets or Confidential Information of the Company at any time after termination of employment and prior to such time as they cease to be Trade Secrets or Confidential Information through no act of the Executive in violation of this Section.

Upon termination of employment, Executive will surrender to the Company all memoranda, notes, records, plans, manuals or other documents pertaining to the Company's business or the Executive's employment (including all copies thereof). The Executive will also leave with the Company all materials involving Trade Secrets or Confidential Information of the Company. All such information and materials, whether or not made or developed by the Executive, shall be the sole and exclusive property of the Company, and the Executive hereby assigns to the Company all of the Executive's right, title and interest in and to any and all of such information and materials.

Agreement Not to Compete and Agreement Not to Solicit

The Executive hereby covenants and agrees that, for a period commencing on the Restrictive Covenants Effective Date and ending at the conclusion of the applicable Severance Period (as defined in the Humana Inc. Executive Severance Policy (the "Policy")), the Executive, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, stockholder, investor or principal of, or consultant or independent contractor with, another entity, shall not participate in any business which competes with the Company including, without limitation, health maintenance organizations, insurance companies or prepaid health plan businesses in which the

Company has been actively engaged during any part of the two (2) year period immediately preceding the Date of Termination (as defined in the Policy) ("Company Business"), in any Geographic Area (as defined below) in which the Company and/or any of its Affiliates is then doing business. For purposes of this Policy, "Geographic Area" means any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

The Executive hereby covenants and agrees that, for a period commencing on the Restrictive Covenants Effective Date and ending at the conclusion of the applicable Severance Period, the Executive, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, stockholder, investor or principal of, or consultant or independent contractor with, another entity, shall not: (1) interfere with the relationship of the Company and any of its employees, agents, representatives, consultants or advisors; (2) divert, or attempt to cause the diversion from the Company, any Company Business, nor interfere with relationships of the Company with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers; or (3) solicit, recruit or otherwise induce or influence any employee of the Company to accept employment in any business which competes with the Company Business, in any Geographic Area in which the Company and/or any of its Affiliates is then doing business.

Exhibit 10(ff)

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Restricted Stock Units. Each Restricted Stock Unit represents the right of Grantee to receive (i) one (1) Share on the date of distribution provided for in Section I.E. In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("**DERs**"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I.E. hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I.B through I.E., inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I.D. hereof, the related DER shall also be forfeited.

B. Restrictions and Non-Transferability. The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I.D.

C. Vesting of Restricted Stock Units. The Restricted Stock Units shall vest in three equal installments, with the first installment vesting on [December 15] of the year in which the Date of Grant occurs, and the next two installments vesting on [December 15] of each of the next two years (each such date, a "**Vesting Date**" and the period between each Vesting Date or between the Date of Grant and a

Vesting Date, as applicable, a "**Vesting Period**") subject to Grantee's continued employment with the Company through each such Vesting Date; provided, that, notwithstanding the foregoing, upon certain terminations (as set forth below), all or a portion of the unvested Restricted Stock Units and DERs will vest as follows:

1. Upon a termination of Grantee's employment with the Company due to Grantee's death or Disability, all of the unvested Restricted Stock Units and DERs will immediately vest;

2. In the event of a Change in Control Termination, all of the unvested Restricted Stock Units and DERs will immediately vest;

3. Upon the termination of Grantee's employment due to Retirement, a prorated portion of the Restricted Stock Units (and related DERs) that would have vested on the next scheduled Vesting Date shall vest on the next scheduled Vesting Date, with the proration to be determined by calculating the product of (i) the quotient of (x) the number of completed months Grantee has been employed since the Date of Grant or the most recent Vesting Date, as applicable, divided by (y) the number of months in the current restricted Vesting Period, multiplied by (ii) the total number of Restricted Stock Units that were scheduled to vest on the next scheduled Vesting Date. For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant;

4. [In the event that Grantee's employment with the Company terminates due to a Divestiture of the business to which Grantee provides services and (i) the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion, all outstanding Restricted Stock Units (and related DERs) shall continue to vest on the regular Vesting Dates in the same manner as if Grantee continued to be employed by the Company through the applicable Vesting Dates; provided that the Grantee must remain employed by the divested business on each of the applicable Vesting Dates. For the avoidance of doubt, if the Grantee's employment with the aforementioned divested business terminates before a Vesting Date, the Grantee's unvested Restricted Stock Units will no longer vest pursuant to this Section I.C.4 and will be forfeited upon such termination; or (ii) the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, the portion of the unvested Restricted Stock Units (and related DERs) that would ordinarily vest within twelve (12) months of the termination of employment due to a Divestiture shall continue to vest and become vested on regular Vesting Date(s) as if Grantee had remained employed by the Company through such dates][1];

5. [In the event that Grantee's employment with the Company terminates due to a Workforce Reduction or a Position Elimination, the portion of the unvested Restricted Stock Units (and related DERs) that would ordinarily vest within twelve (12) months of the termination of employment due to a Workforce Reduction or a Position Elimination shall continue to vest and become vested on regular Vesting Date(s) as if Grantee had remained employed by the Company through such Vesting Dates; and][2]

[1] NTD: Applicable for annual awards. Remove for new hires.
[2] NTD: Applicable for annual awards. Remove for new hires.

6. In the event that Grantee's employment with the Company terminates due to a transfer to a Strategic Joint Venture, [due to a Divestiture of the business to which Grantee provides services, or due to a Workforce Reduction or a Position Elimination,][3] all outstanding Restricted Stock Units (and related DERs) shall continue to vest on the regular Vesting Date(s) in the same manner as if Grantee continued to be employed by the Company through the applicable Vesting Date(s)[; provided that, in the case of a termination due to a Divestiture of the business, if the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion, the Grantee must remain employed by the divested business on each of the applicable Vesting Dates. For the avoidance of doubt, if the Grantee's employment with the aforementioned divested business terminates prior to a Vesting Date, the Grantee's unvested Restricted Stock Units will no longer vest pursuant to this Section I.C.6 and will be forfeited upon such termination.][4]

D. Forfeiture. Except as set forth in Section I.C, upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

E. Distributions. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I.C hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination, then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I.C. hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. Taxes. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the

[3] NTD: Applicable for new hires. Remove for annual awards.
[4] NTD: Applicable for new hires. Remove for annual awards.

Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. **AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.** Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. **Agreement Not to Compete.** Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform the same or similar responsibilities Grantee performed for the Company in connection with a Competitive Product or Service (defined below). Notwithstanding the foregoing, Grantee may accept employment with a Competitor (defined below) whose business is diversified, provided that: (1) Grantee will not be engaged in working on or providing Competitive Products or Services, or otherwise use or disclose the Company's confidential information or trade secrets; and (2) the Company receives written assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee will not work on or provide Competitive Products or Services, or otherwise use or disclose confidential information or trade secrets. In addition, nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. **Agreement Not to Solicit Protected Relationships.** During the Restricted Period and in connection with a Competitive Product or Service, Grantee shall not, individually or jointly with others, directly or indirectly: (1) solicit or attempt to solicit any Protected Relationships (defined below); or (2) induce or encourage any Protected Relationships to terminate a relationship with the Company or to otherwise cease to accept services or products from the Company.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly: (1) or by assisting others, solicit, recruit, hire, or encourage (or attempt to solicit, recruit, hire or encourage), any Company employees or former employees with whom Grantee worked, had business contact, or about whom Grantee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of inducing, assisting, encouraging and/or facilitating them to terminate their employment with the Company or find employment or work with another person or entity; (3) provide or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company at the time of the attempted recruiting or hiring, but were employed by, or working for the Company in the three (3) months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II.A, II.B and II.C. shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II.A shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the acceleration or continuation of the vesting of the Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited, with such value measured by multiplying the number of Shares underlying the Restricted Stock Units that vested as a result of the termination of employment by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II.B and II. C above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D, in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Grantee's employment termination date with the Company or its successor, to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II.E shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II.B. and II C. shall remain in full force and effect.

F. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. Injunctive Relief; Invalidity of Any Provision. Grantee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Grantee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and

as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. No Employment Agreement. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in

Control, if the employment of Grantee is terminated within two (2) years following the Change in Control (i) by the Company or its acquirer or successor for any reason other than Cause or (ii) by Grantee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked or for which Grantee had responsibilities at the Company during the twenty-four (24) months prior to the Last Day (as defined below).

(iii) "**Competitor**" means Grantee or any other person or organization engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Divestiture**" means the sale or other transfer of equity securities of a Subsidiary to a person or entity other than the Company or an affiliate of the Company, or if a Subsidiary leases, exchanges or transfers all or any portion of its assets to such a person or entity, then the Committee may specify that such transaction or event constitutes a "Divestiture".

(v) "**Good Reason**" shall mean, unless otherwise defined in a written employment agreement in effect between the Company or any of its Subsidiaries and Grantee, the relocation of Grantee's office at which Grantee is to perform his or her duties to a location more than thirty (30) miles from the location at which Grantee performed his or her duties prior to a Change in Control.

(vi) "**Last Day**" means Grantee's last day of employment with the Company regardless of the reason for Grantee's separation.

(vii) "**Position Elimination**" means the elimination of Grantee's position.

(viii) "**Protected Relationship**" means policyholders, agents, brokers, dealers, distributers, sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Grantee, directly or indirectly (e.g., through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(ix) "**Restricted Geographic Area**" means the territory (i.e.: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(x) "**Restricted Period**" means the period of Grantee's employment with the Company and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's legitimate business interest and need for protection with each position.

(xi) "**Strategic Joint Venture**" means a business arrangement entered into by the Company with one or more other parties to own and operate an entity in which the Company continues to have a strategic interest.

(xii) "**Workforce Reduction**" means a reduction in force, as determined by the Company in accordance with its standard coding procedures.

G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer & Corporate Secretary

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

Exhibit 10(gg)

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT WITH PERFORMANCE VESTING
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>**,** an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Performance-Based Restricted Stock Units (the "**Restricted Stock Units**") (which represents the target amount of shares available as set out on Appendix A). Each Restricted Stock Unit represents the right of Grantee to receive (i) one (1) Share on the date of distribution provided for in Section I.E. In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("**DERs**"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I.E. hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I.B through I.E., inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I.D. hereof, the related DER shall also be forfeited.

B. Restrictions and Non-Transferability. The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I.D.

C. Vesting of Shares. Subject to the terms set forth below, if as of the third anniversary of the Date of Grant (the "**Vesting Date**" and the period between the Date of Grant and the Vesting Date, a "**Vesting Period**"), Grantee and the Company have achieved the performance goals to be set forth in

Appendix A, the Restricted Stock Units and related DERs shall vest to the extent such performance goals have been achieved. Effective on the Vesting Date, any portion of the Restricted Stock Units and the related DERs for which the performance goals set forth in Appendix A have not been satisfied shall be immediately forfeited; provided, however, notwithstanding the foregoing, upon certain terminations of employment (as set forth below), all or a portion of the unvested Restricted Stock Units and DERs will vest as follows:

1. Upon a termination of Grantee's employment with the Company due to Grantee's death or Disability, all of the unvested Restricted Stock Units and DERs will immediately vest at target level;

2. In the event of a Change in Control Termination, all of the unvested Restricted Stock Units and DERs will immediately vest at target levels;

3. Upon the termination of Grantee's employment due to Retirement, [Position Elimination, Workforce Reduction][1] or a Divestiture of the business to which Grantee provides services if the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, a prorated portion of the Restricted Stock Units (and related DERs) that would have vested on the next scheduled Vesting Date shall vest on the next scheduled Vesting Date, with the proration to be determined by calculating the product of (A) the quotient of (x) the number of completed months Grantee has been employed since the Date of Grant, divided by (y) the number of months in the current restricted Vesting Period, multiplied by (B) the total number of Restricted Stock Units that would have vested on the next scheduled Vesting Date (taking into account achievement of applicable performance goals). For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant; or

5. Upon the termination of Grantee's employment due to [Position Elimination, Workforce Reduction][2] or a Divestiture of the business to which Grantee provides services if the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion, or due to a transfer to a Strategic Joint Venture, Grantee shall continue to vest in the Restricted Stock Units (and related DERs) as if Grantee remained employed through the applicable Vesting Date (taking into account achievement of applicable performance goals); provided that, in the case of a termination due to a Divestiture of the business, the Grantee must remain employed by the divested business on the applicable Vesting Dates. For the avoidance of doubt, if the Grantee's employment with the aforementioned divested business terminates prior to a Vesting Date, the Grantee's unvested Restricted Stock Units will no longer vest pursuant to this Section I.C.5 and will be forfeited upon such termination.

D. Forfeiture. Except as set forth in Section I.C, upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

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[1] NTD: Applicable for annual awards. Remove for new hires.
[2] NTD: Applicable for new hires. Remove for annual awards.

E. **Distributions**. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I.C hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination (defined below), then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I.C. hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. **Taxes**. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. **AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.**

Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to

restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete. Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform the same or similar responsibilities Grantee performed for the Company in connection with a Competitive Product or Service (defined below). Notwithstanding the foregoing, Grantee may accept employment with a Competitor (defined below) whose business is diversified, provided that: (1) Grantee will not be engaged in working on or providing Competitive Products or Services, or otherwise use or disclose the Company's confidential information or trade secrets; and (2) the Company receives written assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee will not work on or provide Competitive Products or Services, or otherwise use or disclose confidential information or trade secrets. In addition, nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period and in connection with a Competitive Product or Service, Grantee shall not, individually or jointly with others, directly or indirectly: (1) solicit or attempt to solicit any Protected Relationships (defined below); or (2) induce or encourage any Protected Relationships to terminate a relationship with the Company or to otherwise cease to accept services or products from the Company.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly: (1) or by assisting others, solicit, recruit, hire, or encourage (or attempt to solicit, recruit, hire or encourage), any Company employees or former employees with whom Grantee worked, had business contact, or about whom Grantee gained non-public or confidential information ("**Employees or Former Employees**"); (2) contact or communicate with Employees or Former Employees for the purpose of inducing, assisting, encouraging and/or facilitating them to terminate their employment with the Company or find employment or work with another person or entity; (3) provide or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company at the time of the attempted recruiting or hiring, but were employed by, or working for the Company in the three (3) months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II.A, II.B and II.C. shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II.A shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Restricted Stock Units that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Restricted Stock Units. assuming target performance has been achieved (or by the number of Shares underlying the Restricted Stock Unit that become vested as a result of the acceleration of vesting, if any). by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II.B and II. C above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D, in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Grantee's employment termination date with the Company or its successor, to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section

II.E shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II.B. and II.C. shall remain in full force and effect.

F. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. Injunctive Relief; Invalidity of Any Provision. Grantee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Grantee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. **Amendment**. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. **Governing Law.** Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. **No Employment Agreement**. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. **Severability.** If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

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1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

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(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked or for which Grantee had responsibilities at the Company during the twenty-four (24) months prior to the Last Day (as defined below).

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(vi) "**Last Day**" means Grantee's last day of employment with the Company regardless of the reason for Grantee's separation.

(vii) "**Position Elimination**" means the elimination of Grantee's position.

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G. **Execution**. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. **Section 409A**. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this

intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer & Corporate Secretary

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

APPENDIX A

Payout Matrix for Performance-Based Restricted Stock Units

The <shares_awarded> Restricted Stock Units represent the target number of shares of common stock that could potentially be earned on the Vesting Date if the below strategic measure is achieved at the target level. Performance above or below the target level will yield vesting of a different amount of shares of common stock, according to the following matrix:

Exhibit 10(hh)

HUMANA INC.
INCENTIVE STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to grant to Optionee an option to purchase shares of common stock of the Company in accordance with the Plan;

NOW, THEREFORE, in consideration of the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

I. OPTION GRANT

A. Grant of Option. The Company hereby grants to Optionee, as a matter of separate inducement and agreement and not in lieu of salary or other compensation for services, an Incentive Stock Option to purchase <shares_awarded> shares of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of <award_price> per share (the **"Option"**) exercisable on the terms and conditions set forth herein.

B. Term. The term of the Option shall commence upon the Date of Grant, and shall expire on <expire_Date> (the "**Expiration Date**").

C. Vesting of Option. Except as otherwise set forth herein, the Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the Date of Grant in cumulative annual installments of one-third of the number of Shares covered hereby (each such date, a "**Vesting Date**" and the period between each Vesting Date or between the Date of Grant and a Vesting Date, as applicable, a "**Vesting Period**"), subject to Optionee's continued employment with the Company through each Vesting Date, except as set forth in Section D below.

D. Effect of Termination of Employment on Option. If the employment of Optionee is terminated for any reason, the Option shall vest and remain exercisable as follows, but in no event beyond the Expiration Date:

1. If the employment of Optionee is terminated by the Company for Cause, all the rights of Optionee under this Agreement, whether or not exercisable, shall terminate immediately.

2. In the event of Optionee's Retirement, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such Retirement, this Option (or portion hereof) shall be exercisable

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at any time within two (2) years after the date of Retirement, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of Retirement, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such Retirement, a prorated portion of the Option that would have vested on the next scheduled Vesting Date shall vest and become exercisable upon the next scheduled Vesting Date, with the proration to be determined by calculating the product of (A) the quotient of (x) the number of completed months Optionee has been employed since the Date of Grant or the most recent Vesting Date, as applicable, divided by (y) the number of months in the current Vesting Period, multiplied by (B) the total number of Options that were scheduled to vest and become exercisable on the next scheduled Vesting Date. For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant. The portion of the Option that vests pursuant to clause (ii) of this Section I.D.2 shall be exercisable at any time within two (2) years following the date of Optionee's Retirement, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's Retirement and could not become exercisable after taking into account the provisions of this Section I.D.2. shall be immediately forfeited upon Optionee's Retirement. Any portion of the Option that is not exercisable on the date of Optionee's Retirement and could not become exercisable after taking into account the provisions of this Section I.D.2. shall be immediately forfeited upon Optionee's Retirement.

3. In the event of termination due to death or Disability of Optionee while in the employ of the Company, this Option shall become fully vested and exercisable of the termination due to death or Disability of Optionee and shall remain exercisable by Optionee or the person or the persons to whom those rights pass by will or by the laws of descent and distribution or, if appropriate, by the legal representative of Optionee or the estate of Optionee at any time within two (2) years after the date of such death or the date of determination of Disability, but in no event beyond the Expiration Date.

4. In the event that Optionee's employment with the Company terminates due to a Divestiture of the business to which Optionee provides services, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of such termination of employment, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, [and (A) the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion,][1] the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates through the date that the Option would become fully vested; provided that[, in the event the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion,][2] the Optionee must remain employed by the divested business on each of the

[1] NTD: Applicable only for annual award. Remove for new hire.
[2] NTD: Applicable only for new hire. Remove for annual award.

applicable Vesting Dates. For the avoidance of doubt, if the Optionee's employment with the aforementioned divested business terminates prior to a Vesting Date, the Optionee's unvested Option will no longer vest pursuant to this Section I.D.4 and will be forfeited upon such termination; [or (B) the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates that would occur during the twelve (12) month period immediately following the termination of Optionee's employment as if Optionee continued to be employed by the Company during such period,][3] and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.4. shall be immediately forfeited upon Optionee's termination of employment.

5. In the event that Optionee's employment with the Company terminates due to a Workforce Reduction or a Position Elimination, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable in accordance with this Section I.D.6, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates that would occur [during the twelve (12) month period immediately following the termination of Optionee's employment][4] as if Optionee continued to be employed by the Company, and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.5. shall be immediately forfeited upon Optionee's termination of employment.

6. In the event that Optionee's employment with the Company terminates due to a transfer to a Strategic Joint Venture, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of such termination of employment, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates through the date that

[3] NTD: Applicable only for annual award. Remove for new hire.
[4] NTD: Applicable for annual awards. Remove for new hires.

the Option would become fully vested as if Optionee continued to be employed through such Vesting Date, and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.6. shall be immediately forfeited upon Optionee's termination of employment.

7. In the event of a Change in Control Termination, this Option (or any option or other award for which this Option is substituted or into which this Option is converted into in connection with the Change in Control) shall become fully vested and immediately exercisable in its entirety, and this Option (or any substitute or converted award) shall remain exercisable at any time within two (2) years after the date of termination of Optionee's employment, but in no event beyond the Expiration Date.

8. If the employment of Optionee terminates for any reason other than for Cause, Retirement, death or Disability, Position Elimination, Workforce Reduction, Divestiture, due to a transfer to a Strategic Joint Venture or as a result of a Change in Control Termination, unless otherwise specified herein, all the rights of Optionee under this Agreement then exercisable shall remain exercisable at any time within ninety (90) days after the later of the date of such termination and the last date that the Option vests pursuant to the terms of this Agreement, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of the Optionee's termination of employment and could not become exercisable after taking into account the provision of Section I.D. shall be immediately forfeited upon Optionee's termination of employment.

E. Exercise of Option.

1. The Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the online procedure to such broker-dealer as designated by the Company, Optionee or his/her legal representative as herein provided. Such notice shall state the number of Shares with respect to which the Option is being exercised and shall be signed, or authorized electronically, by Optionee or his/her legal representative, as applicable.

2. The purchase price shall be paid as follows:

a) In full in cash upon the exercise of the Option;

b) By tendering to the Company Shares owned by Optionee prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to the Option; or

c) A combination of I.E.(2)(a) and I.E.(2)(b) above.

3. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company (**"Withholding Taxes"**) in connection with the exercise of the Option shall be paid pursuant to the Plan by Optionee prior to the delivery of any Common Stock under this Agreement. The Company shall, at Optionee's election, withhold delivery of a number of Shares with a Fair Market Value as of the exercise date equal to the Withholding Taxes in satisfaction of Optionee's obligations hereunder.

II. **AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.** Optionee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Optionee) that it is providing Optionee, and in the significant time, money, training, team building and other efforts it expends to develop Optionee's skills to assist in performing Optionee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Optionee agrees are valuable assets of the Company to which it has devoted substantial resources. Optionee acknowledges that the grant Optionee is receiving under the Plan is a meaningful way that the Company entrusts Optionee with its goodwill and aligns Optionee with the Company objective of increasing the value of the Company's business. Accordingly, Optionee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Optionee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. **Agreement Not to Compete.** Optionee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Optionee will not, directly or indirectly, perform the same or similar responsibilities Optionee performed for the Company in connection with a Competitive Product or Service (defined below). Notwithstanding the foregoing, Optionee may accept employment with a Competitor (defined below) whose business is diversified, provided that: (1) Optionee will not be engaged in working on or providing Competitive Products or Services, or otherwise use or disclose the Company's confidential information or trade secrets; and (2) the Company receives written assurances from the Competitor and Optionee that are satisfactory to the Company that Optionee will not work on or provide Competitive Products or Services, or otherwise use or disclose confidential information or trade secrets. In addition, nothing in this Agreement is intended to prevent Optionee from investing Optionee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Optionee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. **Agreement Not to Solicit Protected Relationships.** During the Restricted Period and in connection with a Competitive Product or Service, Optionee shall not, individually or jointly with others, directly or indirectly: (1) solicit or attempt to solicit any Protected Relationships (defined below); or (2) induce or encourage any Protected Relationships to terminate a relationship with the Company or to otherwise cease to accept services or products from the Company.

C. **Agreement Not to Solicit Employees.** During the Restricted Period, Optionee shall not, individually or jointly with others, directly or indirectly: (1) or by assisting others, solicit, recruit, hire, or encourage (or attempt to solicit, recruit, hire or encourage), any Company employees or former employees with whom Optionee worked, had business contact, or about whom Optionee gained non-public or

confidential information ("**Employees or Former Employees**"); (2) contact or communicate with Employees or Former Employees for the purpose of inducing, assisting, encouraging and/or facilitating them to terminate their employment with the Company or find employment or work with another person or entity; (3) provide or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company at the time of the attempted recruiting or hiring, but were employed by, or working for the Company in the three (3) months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Optionee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Option, the prohibitions on Optionee set forth in Sections II.A, II.B and II.C shall remain in full force and effect.

2. In the event Optionee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Option, the prohibitions set forth in Section II.A shall remain in full force and effect during the period of time following Optionee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Optionee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Optionee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the acceleration or continuation of the vesting of any Options as a result of Optionee's termination under this Agreement or the Plan that would otherwise have been forfeited, with such value measured by multiplying the number of Shares underlying the Options that vested as a result of the termination of employment by the difference of the per Share Fair Market Value on the Last Day minus the applicable per Share exercise price, divided by (B) Optionee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Optionee, in its discretion.

3. In the event Optionee is discharged by Company other than with Cause prior to vesting herein of the Option, the prohibitions set forth in Sections II.B and II.C above shall remain in full force and effect.

4. After the vesting of the Option, the prohibitions on Optionee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D., in the event of a Change in Control Termination, the prohibitions on Optionee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Optionee's employment termination date with the Company or its successor, to Optionee the Non-Compete Payment. Notwithstanding any previous agreement between Optionee and the Company relating to the prohibitions set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Optionee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Optionee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II.E shall supersede any agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Optionee and the Company, (ii) any agreement between Optionee and the Company not related to the employment of Optionee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Optionee set forth in Sections II.B. and II C. shall remain in full force and effect.

F. **Governing Law.** Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. **Injunctive Relief; Invalidity of Any Provision**. Optionee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Optionee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Optionee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Optionee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Optionee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Optionee and all rights granted to Optionee and to the Company shall be binding upon Optionee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. Jurisdiction; Service of Process. Any action or proceeding seeking to enforce any provision of, or based on any right arising out of, this Agreement may be brought against any of the parties in the courts of the Commonwealth of Kentucky, County of Jefferson, or, if it has or can acquire jurisdiction, in the United States District Court for the Western District of Kentucky, and each of the parties consents to the jurisdiction of such courts (and of the appropriate appellate courts) in any such action or proceeding and waives any objection to venue laid therein. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere in the world.

E. No Employment Agreement. Nothing herein confers on Optionee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Optionee's employment or other service at any time.

F. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect. Any provision in this Agreement determined by competent authority to be in conflict with 422 of the Internal Revenue Code of 1986, as amended, or its successor, in regard to qualifying this Option as an incentive stock option shall be ineffective ab initio to the extent of such conflict.

G. Assignment. The Option granted under this Agreement to Optionee may not be assigned, transferred, pledged, alienated or hypothecated in any manner during Optionee's lifetime, but shall be solely and exclusively the right of Optionee to exercise during his/her lifetime. Should Optionee attempt to assign,

transfer, pledge, alienate or hypothecate the Option or any rights hereunder in any manner whatsoever, such action shall constitute a breach of the covenants hereunder and the Company may terminate the Option as to any then unexercised shares.

H. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Optionee and any person or persons claiming through Optionee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event the Option is assumed, converted, continued or substituted in connection with a Change in Control, if the employment of Optionee is terminated within two (2) years following the Change in Control (i) by the Company or its acquirer or successor for any reason other than Cause or (ii) by Optionee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Optionee worked or for which Optionee had responsibilities at the Company during the twenty-four (24) months prior to the Last Day (as defined below).

(iii) "**Competitor**" means Optionee or any other person or organization engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Divestiture**" means the sale or other transfer of equity securities of a Subsidiary to a person or entity other than the Company or an affiliate of the Company, or if a Subsidiary leases, exchanges or transfers all or any portion of its assets to such a person or entity, then the Committee may specify that such transaction or event constitutes a "Divestiture".

(v) "**Good Reason**" shall mean, unless otherwise defined in a written employment agreement in effect between the Company or any of its Subsidiaries and Optionee, the relocation of Optionee's office at which Optionee is to perform his or her duties to a location more than thirty (30) miles from the location at which Optionee performed his or her duties prior to a Change in Control.

(vi) "**Last Day**" means Optionee's last day of employment with the Company regardless of the reason for Optionee's separation.

(vii) "**Position Elimination**" means the elimination of Optionee's position.

(viii) "**Protected Relationship**" means policyholders, agents, brokers, dealers, distributers, sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Optionee, directly or indirectly (e.g., through employees whom Optionee supervised) had material business contact and/or about whom Optionee obtained confidential information and trade secrets.

(ix) "**Restricted Geographic Area**" means the territory (i.e.: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Optionee provided material services on behalf of the Company (or in which Optionee supervised directly, indirectly, in whole or in part, the servicing activities).

(x) "**Restricted Period**" means the period of Optionee's employment with the Company and a period of twelve (12) months after the Last Day. Optionee recognizes that the durational term is reasonably and narrowly tailored to the Company's legitimate business interest and need for protection with each position.

(xi) "**Strategic Joint Venture**" means a business arrangement entered into by the Company with one or more other parties to own and operate an entity in which the Company continues to have a strategic interest.

(xii) "**Workforce Reduction**" means a reduction in force, as determined by the Company in accordance with its standard coding procedures.

I. **Execution.** If Optionee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Optionee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer & Corporate Secretary

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Optionee"

_____
<first_name> <middle_name> <last_name>

Exhibit 10(ii)

HUMANA INC.
STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to grant to Optionee an option to purchase shares of common stock of the Company in accordance with the Plan;

NOW, THEREFORE, in consideration of the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

I. OPTION GRANT

A. Grant of Option. The Company hereby grants to Optionee, as a matter of separate inducement and agreement and not in lieu of salary or other compensation for services, a Non-Qualified Stock Option to purchase <shares_awarded> shares of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of <award_price> per share (the **"Option"**) exercisable on the terms and conditions set forth herein.

B. Term. The term of the Option shall commence upon the Date of Grant, and shall expire on <expire_Date> (the "**Expiration Date**").

C. Vesting of Option. Except as otherwise set forth herein, the Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the Date of Grant in cumulative annual installments of one-third of the number of Shares covered hereby (each such date, a "**Vesting Date**" and the period between each Vesting Date or between the Date of Grant and a Vesting Date, as applicable, a "**Vesting Period**"), subject to Optionee's continued employment with the Company through each Vesting Date, except as set forth in Section D below.

D. Effect of Termination of Employment on Option. If the employment of Optionee is terminated for any reason, the Option shall vest and remain exercisable as follows:

1. If the employment of Optionee is terminated by the Company for Cause, all the rights of Optionee under this Agreement, whether or not exercisable, shall terminate immediately.

2. In the event of Optionee's Retirement, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such Retirement, this Option (or portion hereof) shall be exercisable

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at any time within two (2) years after the date of Retirement, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of Retirement, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such Retirement, a prorated portion of the Option that would have vested on the next scheduled Vesting Date shall vest and become exercisable upon the next scheduled Vesting Date, with the proration to be determined by calculating the product of (A) the quotient of (x) the number of completed months Optionee has been employed since the Date of Grant or the most recent Vesting Date, as applicable, divided by (y) the number of months in the current Vesting Period, multiplied by (B) the total number of Options that were scheduled to vest and become exercisable on the next scheduled Vesting Date. For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant. The portion of the Option that vests pursuant to clause (ii) of this Section I.D.2 shall be exercisable at any time within two (2) years following the date of Optionee's Retirement, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's Retirement and could not become exercisable after taking into account the provisions of this Section I.D.2. shall be immediately forfeited upon Optionee's Retirement. Any portion of the Option that is not exercisable on the date of Optionee's Retirement and could not become exercisable after taking into account the provisions of this Section I.D.2. shall be immediately forfeited upon Optionee's Retirement.

3. In the event of termination due to death or Disability of Optionee while in the employ of the Company, this Option shall become fully vested and exercisable of the termination due to death or Disability of Optionee and shall remain exercisable by Optionee or the person or the persons to whom those rights pass by will or by the laws of descent and distribution or, if appropriate, by the legal representative of Optionee or the estate of Optionee at any time within two (2) years after the date of such death or the date of determination of Disability, regardless of the Expiration Date.

4. In the event that Optionee's employment with the Company terminates due to a Divestiture of the business to which Optionee provides services, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of such termination of employment, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, [and (A) the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion,][1] the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates through the date that the Option would become fully vested; provided that[, in the event the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion,][2] the Optionee must remain employed by the divested business on each of the

[1] NTD: Applicable only for annual award. Remove for new hire.
[2] NTD: Applicable only for new hire. Remove for annual award.

applicable Vesting Dates. For the avoidance of doubt, if the Optionee's employment with the aforementioned divested business terminates prior to a Vesting Date, the Optionee's unvested Option will no longer vest pursuant to this Section I.D.4 and will be forfeited upon such termination; [or (B) the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates that would occur during the twelve (12) month period immediately following the termination of Optionee's employment as if Optionee continued to be employed by the Company during such period,][3] and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.4. shall be immediately forfeited upon Optionee's termination of employment.

5. In the event that Optionee's employment with the Company terminates due to a Workforce Reduction or a Position Elimination, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable in accordance with this Section I.D.6, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates that would occur [during the twelve (12) month period immediately following the termination of Optionee's employment][4] as if Optionee continued to be employed by the Company, and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.5. shall be immediately forfeited upon Optionee's termination of employment.

6. In the event that Optionee's employment with the Company terminates due to a transfer to a Strategic Joint Venture, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of such termination of employment, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates through the date that

[3] NTD: Applicable for annual awards. Remove for new hires.
[4] NTD: Applicable for annual awards. Remove for new hires.

the Option would become fully vested as if Optionee continued to be employed through such Vesting Date, and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.6. shall be immediately forfeited upon Optionee's termination of employment.

7. In the event of a Change in Control Termination, this Option (or any option or other award for which this Option is substituted or into which this Option is converted into in connection with the Change in Control) shall become fully vested and immediately exercisable in its entirety, and this Option (or any substitute or converted award) shall remain exercisable at any time within two (2) years after the date of termination of Optionee's employment, but in no event beyond the Expiration Date.

8. If the employment of Optionee terminates for any reason other than for Cause, Retirement, death or Disability, Position Elimination, Workforce Reduction, Divestiture, due to a transfer to a Strategic Joint Venture or as a result of a Change in Control Termination, unless otherwise specified herein, all the rights of Optionee under this Agreement then exercisable shall remain exercisable at any time within ninety (90) days after the later of the date of such termination and the last date that the Option vests pursuant to the terms of this Agreement, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of the Optionee's termination of employment and could not become exercisable after taking into account the provision of Section I.D. shall be immediately forfeited upon Optionee's termination of employment.

E. Exercise of Option.

1. The Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the online procedure to such broker-dealer as designated by the Company, Optionee or his/her legal representative as herein provided. Such notice shall state the number of Shares with respect to which the Option is being exercised and shall be signed, or authorized electronically, by Optionee or his/her legal representative, as applicable.

2. The purchase price shall be paid as follows:

a) In full in cash upon the exercise of the Option;

b) By tendering to the Company Shares owned by Optionee prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to the Option;

c) A combination of I.E.(2)(a) and I.E.(2)(b) above; or

(d) Through the cashless exercise provisions of the designated broker-dealer as described in the procedures communicated to Optionee by the Company.

3. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company (**"Withholding Taxes"**) in connection with the exercise of the Option shall be paid pursuant to the Plan by Optionee prior to the delivery of any Common Stock under this Agreement. The Company shall, at Optionee's election, withhold delivery of a number of Shares

with a Fair Market Value as of the exercise date equal to the Withholding Taxes in satisfaction of Optionee's obligations hereunder.

II. **AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.** Optionee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Optionee) that it is providing Optionee, and in the significant time, money, training, team building and other efforts it expends to develop Optionee's skills to assist in performing Optionee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Optionee agrees are valuable assets of the Company to which it has devoted substantial resources. Optionee acknowledges that the grant Optionee is receiving under the Plan is a meaningful way that the Company entrusts Optionee with its goodwill and aligns Optionee with the Company objective of increasing the value of the Company's business. Accordingly, Optionee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Optionee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. **Agreement Not to Compete.** Optionee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Optionee will not, directly or indirectly, perform the same or similar responsibilities Optionee performed for the Company in connection with a Competitive Product or Service (defined below). Notwithstanding the foregoing, Optionee may accept employment with a Competitor (defined below) whose business is diversified, provided that: (1) Optionee will not be engaged in working on or providing Competitive Products or Services, or otherwise use or disclose the Company's confidential information or trade secrets; and (2) the Company receives written assurances from the Competitor and Optionee that are satisfactory to the Company that Optionee will not work on or provide Competitive Products or Services, or otherwise use or disclose confidential information or trade secrets. In addition, nothing in this Agreement is intended to prevent Optionee from investing Optionee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Optionee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. **Agreement Not to Solicit Protected Relationships.** During the Restricted Period and in connection with a Competitive Product or Service, Optionee shall not, individually or jointly with others, directly or indirectly: (1) solicit or attempt to solicit any Protected Relationships (defined below); or (2) induce or encourage any Protected Relationships to terminate a relationship with the Company or to otherwise cease to accept services or products from the Company.

C. **Agreement Not to Solicit Employees.** During the Restricted Period, Optionee shall not, individually or jointly with others, directly or indirectly: (1) or by assisting others, solicit, recruit, hire, or

encourage (or attempt to solicit, recruit, hire or encourage), any Company employees or former employees with whom Optionee worked, had business contact, or about whom Optionee gained non-public or confidential information ("**Employees or Former Employees**"); (2) contact or communicate with Employees or Former Employees for the purpose of inducing, assisting, encouraging and/or facilitating them to terminate their employment with the Company or find employment or work with another person or entity; (3) provide or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company at the time of the attempted recruiting or hiring, but were employed by, or working for the Company in the three (3) months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Optionee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Option, the prohibitions on Optionee set forth in Sections II.A, II.B and II.C shall remain in full force and effect.

2. In the event Optionee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Option, the prohibitions set forth in Section II.A shall remain in full force and effect during the period of time following Optionee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Optionee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Optionee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the acceleration or continuation of the vesting of any Options as a result of Optionee's termination under this Agreement or the Plan that would otherwise have been forfeited, with such value measured by multiplying the number of Shares underlying the Options that vested as a result of the termination of employment by the difference of the per Share Fair Market Value on the Last Day minus the applicable per Share exercise price, divided by (B) Optionee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Optionee, in its discretion.

3. In the event Optionee is discharged by Company other than with Cause prior to vesting herein of the Option, the prohibitions set forth in Sections II.B and II.C above shall remain in full force and effect.

4. After the vesting of the Option, the prohibitions on Optionee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D., in the event of a Change in Control Termination, the prohibitions on Optionee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Optionee's employment termination date with the Company or its successor, to Optionee the Non-Compete Payment. Notwithstanding any previous agreement between Optionee and the Company relating to the prohibitions set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Optionee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Optionee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II.E shall supersede any agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Optionee and the Company, (ii) any agreement between Optionee and the Company not related to the employment of Optionee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Optionee set forth in Sections II.B. and II C. shall remain in full force and effect.

F. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. Injunctive Relief; Invalidity of Any Provision. Optionee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Optionee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Optionee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Optionee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Optionee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Optionee and all rights granted to Optionee and to the Company shall be binding upon Optionee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. Jurisdiction; Service of Process. Any action or proceeding seeking to enforce any provision of, or based on any right arising out of, this Agreement may be brought against any of the parties in the courts of the Commonwealth of Kentucky, County of Jefferson, or, if it has or can acquire jurisdiction, in the United States District Court for the Western District of Kentucky, and each of the parties consents to the jurisdiction of such courts (and of the appropriate appellate courts) in any such action or proceeding and waives any objection to venue laid therein. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere in the world.

E. No Employment Agreement. Nothing herein confers on Optionee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Optionee's employment or other service at any time.

F. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

G. Assignment. The Option granted under this Agreement to Optionee may not be assigned, transferred, pledged, alienated or hypothecated in any manner during Optionee's lifetime, but shall be solely and exclusively the right of Optionee to exercise during his/her lifetime. Should Optionee attempt to assign, transfer, pledge, alienate or hypothecate the Option or any rights hereunder in any manner whatsoever,

such action shall constitute a breach of the covenants hereunder and the Company may terminate the Option as to any then unexercised shares.

H. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Optionee and any person or persons claiming through Optionee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event the Option is assumed, converted, continued or substituted in connection with a Change in Control, if the employment of Optionee is terminated within two (2) years following the Change in Control (i) by the Company or its acquirer or successor for any reason other than Cause or (ii) by Optionee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Optionee worked or for which Optionee had responsibilities at the Company during the twenty-four (24) months prior to the Last Day (as defined below).

(iii) "**Competitor**" means Optionee or any other person or organization engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Divestiture**" means the sale or other transfer of equity securities of a Subsidiary to a person or entity other than the Company or an affiliate of the Company, or if a Subsidiary leases, exchanges or transfers all or any portion of its assets to such a person or entity, then the Committee may specify that such transaction or event constitutes a "Divestiture".

(v) "**Good Reason**" shall mean, unless otherwise defined in a written employment agreement in effect between the Company or any of its Subsidiaries and Optionee, the relocation of Optionee's office at which Optionee is to perform his or her duties to a location more than thirty (30) miles from the location at which Optionee performed his or her duties prior to a Change in Control.

(vi) "**Last Day**" means Optionee's last day of employment with the Company regardless of the reason for Optionee's separation.

(vii) "**Position Elimination**" means the elimination of Optionee's position.

(viii) "**Protected Relationship**" means policyholders, agents, brokers, dealers, distributers, sources of supply or customers with whom, within twenty-four (24) months prior to the Last

Day, Optionee, directly or indirectly (e.g., through employees whom Optionee supervised) had material business contact and/or about whom Optionee obtained confidential information and trade secrets.

(ix) "**Restricted Geographic Area**" means the territory (i.e.: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Optionee provided material services on behalf of the Company (or in which Optionee supervised directly, indirectly, in whole or in part, the servicing activities).

(x) "**Restricted Period**" means the period of Optionee's employment with the Company and a period of twelve (12) months after the Last Day. Optionee recognizes that the durational term is reasonably and narrowly tailored to the Company's legitimate business interest and need for protection with each position.

(xi) "**Strategic Joint Venture**" means a business arrangement entered into by the Company with one or more other parties to own and operate an entity in which the Company continues to have a strategic interest.

(xii) "**Workforce Reduction**" means a reduction in force, as determined by the Company in accordance with its standard coding procedures.

I. Execution. If Optionee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Optionee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer & Corporate Secretary

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Optionee"

_____
<first_name> <middle_name> <last_name>

Exhibit 10(jj)

HUMANA INC.
COMPENSATION RECOUPMENT POLICY
(Effective February 21, 2019)

I. Policy and Scope

The Board adopts this recoupment policy under which, upon the occurrence of certain events, the Company's Officers may be required to repay to the Company certain cash and equity incentive-based compensation covered below.

Upon the occurrence of a Triggering Event, the Administrator may, in its sole discretion, after evaluating the associated costs and benefits, recover all or any portion of the Recoverable Incentive paid to a Covered Employee during the Applicable Period. In addition, the Administrator may, in its sole discretion and in the reasonable exercise of its business judgment, determine whether and to what extent additional action is appropriate to address the circumstances surrounding such Triggering Event so as to minimize the likelihood of any recurrence and to impose such other discipline as it deems appropriate.

II. Definitions

For the purposes of this Policy, the following terms have the following meanings:

A. "**Administrator**" means the Board, the Compensation Committee or such other committee of the Board that, at the relevant time, has authority for making determinations as to the compensation of senior executives.

B. "**Applicable Period**" means (i) with respect to a Restatement, the three-year period preceding the date on which the Company is required to prepare a Restatement and (ii) with respect to Improper Conduct, the three-year period preceding the date on which the Administrator determines that Improper Conduct has occurred.

C. "**Board**" means the Board of Directors of the Company.

D. "**Company**" means Humana Inc.

E. "**Compensation Committee**" means the Organization & Compensation Committee of the Board.

F. "**Covered Employee**" means any Officer of the Company.

G. "**Improper Conduct**" means the following conduct that, in the sole discretion of the Administrator, is likely to cause or has caused material financial, operational, or reputational harm to the Company, materially disrupt, damage, impair or interfere with the business of the Company or its affiliates, or have a significant, adverse reputational or economic impact on the Company or any of its affiliates or divisions:

    i. the commission of an act of fraud, misappropriation or embezzlement in the course of employment;

ii. the commission of a criminal act, whether or not in the workplace, that in the Administrator's sole discretion, constitutes a felony or crime of comparable magnitude;
iii. the material violation of a non-compete, non-solicitation, or confidentiality agreement; or
iv. the willful and material breach of a Covered Employee's obligations under the Company's code of conduct relating to compliance with law or regulation

H. "**Incentive-Based Compensation**" refers to each award of and payment (whether in cash, Company stock, or otherwise) of incentive compensation and other compensation the earning, payment or amount of which depends on the performance of the Company or any individual, product, service, or business unit, including but not limited to annual incentive compensation, awards under commission plans, and awards under the Company's stock incentive plans, including but not limited to gains from the sale or disposition of securities.

I. "**Officer**" shall include any individual who serves as a current or former "Officer" within the meaning set forth in Rule 16a-1(f) of the Securities Exchange Act of 1934, as amended (the "**Exchange Act**"), as applied by the Administrator from time to time.

J. "**Policy**" means this Humana Inc. Compensation Recoupment Policy.

K. "**Recoupment**" means, to the extent permissible under law, offset from amounts otherwise credited, payable, or due, forfeiture or cancellation of awards or amounts deferred, and/or recovery or repayment, as applicable.

L. "**Recoverable Incentive**" means (i) with respect to Recoupment relating to a Restatement, the amount of any Incentive-Based Compensation paid or provided during the Applicable Period that exceeds the amount or value that the Administrator determines, in its sole discretion, would have been payable or received in respect of Incentive-Based Compensation had the revised financial statement(s) reflected in the Restatement been applied to determine the Incentive-Based Compensation or been available to the market at the time such Incentive-Based Compensation was paid or (ii) with respect to Improper Conduct, any Incentive-Based Compensation received by the Covered Employee during and after the period in which such Improper Conduct occurred. In no event will the amount of the Recoverable Incentive exceed the total amount of Incentive-Based Compensation paid or granted during the Applicable Period.

M. "**Restatement**" means the Company being required to undertake any material restatement (occurring after the effective date of this Policy) of any of its financial statements that have been filed with the Securities and Exchange Commission (the "**SEC**") under the Exchange Act or the Securities Act of 1933, as amended.

N. "**Triggering Event**" means either a Restatement or Improper Conduct by a Covered Employee.

III. Administrator Discretion

In exercising the discretion afforded to it under this Policy, the Administrator may consider any and all facts it considers relevant under all of the circumstances, including without limitation: (A) whether or not the Covered Employee engaged in Improper Conduct; (B) the likelihood of success of any recovery under this Policy under governing law as compared to the cost and effort involved; (C) whether the assertion of a claim may prejudice the interests of the Company, including in any related proceeding or investigation; (D) the passage of time since the occurrence of the Triggering Event; and (E) any pending legal proceeding

relating to the Triggering Event. Subject to applicable law, the Administrator may seek to recoup any Recoverable Incentive by requiring any affected Covered Employee to repay such amount to the Company, by set-off, by forfeiture, by reducing future compensation, or by such other means or combination of means as the Administrator, in its sole discretion, determines to be appropriate. The Administrator has sole and absolute discretion with respect to interpretation and enforcement of this Policy and any interpretations or determinations made by the Administrator shall be final and binding on all affected individuals. This Policy will be interpreted and enforced, and appropriate disclosures and filings will be made, in a manner that is consistent with any applicable rules or regulations adopted by the SEC and the New York Stock Exchange pursuant to Section 10D of the Exchange Act, and any other applicable law (collectively, the "**Applicable Rules**"). To the extent the Applicable Rules require the Company to recover Incentive-Based Compensation in additional circumstances besides those specified herein, nothing in this Policy shall be deemed to restrict the right of the Company to recover Incentive-Based Compensation to the fullest extent required by the Applicable Rules. This Policy shall be deemed to be automatically amended, as of the date the Applicable Rules become effective with respect to the Company, to allow the Company to recover Incentive-Based Compensation to the extent required for this Policy to comply with the Applicable Rules.

IV. Recoupment

A. **Restatement**: In the event of a Restatement, the Administrator may recover up to the amount of the Recoverable Incentive received during the Applicable Period if, in the Administrator's judgment and determination, the Covered Employee engaged in fraud, negligence or other misconduct that contributed to the need for the Restatement. For the avoidance of doubt, Restatement does not include any restatement required due to changes in accounting rules or standards or changes in applicable law, or retrospective revisions or reclassifications made to reflect a change in the structure or operations of the Company.

B. **Improper Conduct**: In the event that a Covered Employee engages in Improper Conduct, the Administrator may recover up to the amount of the Recoverable Incentive during the Applicable Period.

V. Method of Recovery

The Administrator may effect Recoupment in any manner consistent with applicable law including, but not limited to, (a) seeking reimbursement of all or part of an award previously paid, (b) cancelling prior awards, whether vested or unvested or paid or unpaid, (c) cancelling or setting-off against planned future grants, and (d) any other method authorized by applicable law or contract.

VII. Amendment and Termination

The Administrator may, from time to time, suspend, discontinue, revise, amend or terminate this Policy in any respect whatsoever. Nothing in this Policy will be deemed to limit or restrict the Company from providing for recoupment, repayment and/or forfeiture of compensation (including Incentive-Based Compensation) under circumstances not set forth in this Policy. In all events, this Policy shall immediately terminate upon the consummation of a Change in Control (as defined in the Company's Change in Control Policy).

VIII. Effective Date

This Policy shall be effective as of the date it is adopted by the Board (the "**Effective Date**") and shall apply to compensation that is awarded or granted to Covered Employees on or after that date (and shall not apply to compensation that is granted or awarded before that date)

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ARKANSAS
1. Humana Regional Health Plan, Inc.

CALIFORNIA
1. Humana EAP and Work-Life Services of California, Inc.
2. Humana Health Plan of California, Inc.

CONNECTICUT
1. SeniorBridge Family Companies (CT), Inc.

DELAWARE
1. Atlantis Physician Group, LLC
2. CDO 1, LLC
3. CDO 2, LLC
4. CompBenefits Corporation
5. CompBenefits Direct, Inc.
6. Emphesys, Inc.
7. Go365, LLC
8. Health Value Management, Inc.
9. HUM Provider Holdings, LLC
10. Humana at Home, Inc.
11. Humana Digital Health and Analytics Platform Services, Inc.
12. Humana Government Business, Inc.
13. Humana Inc.
14. Humana Innovation Enterprises, Inc.
15. Humana Pharmacy, Inc.
16. Humana Veterans Healthcare Services, Inc.
17. Humana WellWorks LLC
18. HumanaDental, Inc.
19. MCCI Group Holdings, LLC
20. MCCI Holdings, LLC
21. North Region Providers, LLC
22. Primary Care Holdings, Inc.
23. Primary Care Holdings II, LLC
24. Primary Care Specialists of the Palm Beaches, LLC
25. Transcend Population Health Management, LLC
26. Transcend Population Health Management II, LLC

FLORIDA
1. 154th Street Medical Plaza, Inc.
2. 54th Street Medical Plaza, Inc.
3. American Eldercare of North Florida, LLC
4. American Eldercare, Inc.
5. CAC Medical Center Holdings, Inc.
6. CAC-Florida Medical Centers, LLC
7. Care Partners Home Care, LLC
8. CarePlus Health Plans, Inc.
9. CompBenefits Company
10. Complex Clinical Management, Inc.
11. Continucare Corporation
12. Continucare MDHC, LLC
13. Continucare Medical Management, Inc.

14. Continucare MSO, Inc.
15. Family Physicians of Winter Park, Inc.
16. FPG Acquisition Corp.
17. FPG Acquisition Holdings Corp.
18. FPG Holding Company, LLC
19. FPG Senior Services, LLC
20. HUM-e-FL, Inc.
21. Humana At Home 1, Inc.
22. Humana Dental Company
23. Humana Health Insurance Company of Florida, Inc.
24. Humana Medical Plan, Inc.
25. MCCI Specialty, LLC
26. MCCI/Lifetime of Aventura, LLC
27. METCARE of Florida, Inc.
28. Metropolitan Health Networks, Inc.
29. Naples Health Care Specialists, LLC
30. Nursing Solutions, LLC
31. Partners in Integrated Care, Inc.
32. RMA Medical Centers of Florida, LLC
33. RMA Medical Group of Florida, LLC
34. SeniorBridge Family Companies (FL), Inc.
35. SeniorBridge-Florida, LLC

GEORGIA
1. Humana Employers Health Plan of Georgia, Inc.

ILLINOIS
1. CompBenefits Dental, Inc.
2. Dental Care Plus Management, Corp.
3. Humana Benefit Plan of Illinois, Inc.
4. Humana Healthcare Research, Inc.

INDIANA
1. SeniorBridge Family Companies (IN), Inc.

KENTUCKY
1. 516-526 West Main Street Condominium Council of Co-Owners, Inc.
2. CHA HMO, Inc.
3. CHA Service Company
4. Humana Active Outlook, Inc.
5. Humana Health Plan, Inc.
6. Humana Insurance Company of Kentucky
7. Humana MarketPOINT, Inc.
8. Humana Pharmacy Solutions, Inc.
9. Humco, Inc.
10. Preservation on Main, Inc.
11. The Dental Concern, Inc.

LOUISIANA
1. Humana Health Benefit Plan of Louisiana, Inc.

MICHIGAN
1. Humana Medical Plan of Michigan, Inc.

MISSOURI
1. SeniorBridge Family Companies (MO), Inc.

NEW YORK
1. Harris, Rothenberg International Inc.
2. Humana Health Company of New York, Inc.
3. Humana Insurance Company of New York
4. SeniorBridge Family Companies (NY), Inc.

OHIO
1. Humana Health Plan of Ohio, Inc.
2. Hummingbird Coaching Systems LLC

PENNSYLVANIA
1. Humana Medical Plan of Pennsylvania, Inc.

PUERTO RICO
1. Humana Health Plans of Puerto Rico, Inc.
2. Humana Insurance of Puerto Rico, Inc.
3. Humana Management Services of Puerto Rico, Inc.
4. Humana MarketPOINT of Puerto Rico, Inc.

TENNESSEE
1. Cariten Health Plan Inc.
2. PHP Companies, Inc.
3. Preferred Health Partnership, Inc.

TEXAS
1. CompBenefits Insurance Company
2. DentiCare, Inc.
3. Emphesys Insurance Company
4. Humana At Home (Dallas), Inc.
5. Humana At Home (Houston), Inc.
6. Humana At Home (San Antonio), Inc.
7. Humana At Home (TLC), Inc.
8. Humana Behavioral Health, Inc.
9. Humana Health Plan of Texas, Inc.
10. Medical Care Consortium Incorporated of Texas
11. ROHC, L.L.C.
12. Texas Dental Plans, Inc.

UTAH
1. Humana Medical Plan of Utah, Inc.

VERMONT
1. Managed Care Indemnity, Inc.

WASHINGTON
1. Arcadian Health Plan, Inc.

WISCONSIN
1. CareNetwork, Inc.
2. Humana Insurance Company
3. Humana Wisconsin Health Organization Insurance Corporation
4. HumanaDental Insurance Company
5. Independent Care Health Plan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (No. 33-49305, No. 333-04435, No. 333-57095, No. 333-86801, No. 333-41408, No. 333-86280, No. 333-105622, No. 333-134887, No. 333-162747, No. 333-171616, and No. 333-175350) and S-3 (No. 333-223554) of Humana Inc. of our report dated February 21, 2019 relating to the financial statements and financial statement schedules and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

February 21, 2019

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Bruce D. Broussard, principal executive officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 21, 2019

Signature: /s/ BRUCE D. BROUSSARD

Bruce D. Broussard
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Brian A. Kane, principal financial officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 21, 2019

Signature: /s/ BRIAN A. KANE

Brian A. Kane
Principal Financial Officer

Exhibit 32

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Humana Inc. (the "Company") on Form 10-K for the period ended December 31, 2018 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ BRUCE D. BROUSSARD

Bruce D. Broussard
President and Chief Executive Officer,
Director (Principal Executive Officer)

February 21, 2019

/s/ BRIAN A. KANE

Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

February 21, 2019

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

Humana serves as a sponsor at the Louisiana Academy of Family Physicians Annual Assembly and Exhibition in Destin, Florida, July 2021.

Section 2.5.6

Required Forms and Certifications

Humana

Healthy Horizons™ in Louisiana

2.5.6 2.5.6 Required Forms and Certifications

2.5.6.1 Exhibit C, Proposal Compliance Matrix: Please refer to **2.5.6.1 Exhibit C - Compliance Matrix.**

2.5.6.2 Exhibit A, Certification Statement: Please refer to **2.5.6.2 Exhibit A - Certification Statement.**

2.5.6.3 Exhibit D, Medicaid Ownership and Disclosure Form: Please refer to **2.5.6.3 Exhibit D - Ownership and Disclosure Form**, provided electronically.

Per Addendum #4, Revision #6 in Part 2 of the Addendum, RFP Section 2.5.6 will be exempt from both the recommended Business Proposal and recommended total page limits.

2.5.6 Required Forms and Certifications

2.5.6.1 Exhibit C, Proposal Compliance Matrix
2.5.6.2 Exhibit A, Certification Statement
2.5.6.3 Exhibit D, Medicaid Ownership and Disclosure Form

(Exhibit D Provided Electronically)

Exhibit C: Proposal Compliance Matrix

RFP #:	3000017417
Proposer:	Humana Health Benefit Plan of Louisiana, Inc.

RFP Section	Requirement	Proposal Section	Proposal Page(s)
2.4	Table of Contents	2.4	1(E) – 3(E)
2.4.1	Cover Letter	2.4.1	4(E)-6(E)
Business Proposal – Section 2.5			
2.5.1	Mandatory Qualifications	2.5.1	1-2
2.5.2	Conflict of Interest	2.5.2	3
2.5.3	Moral or Religious Objections	2.5.3	4
2.5.4	Material Subcontractors	2.5.	5, Ex. B:7(E) – 51(E)
2.5.5	Financial Condition	2.5.5	52(E), Att 2.5.5.1-1 through 2.5.5.1.9, 53(E) – 1003(E)
2.5.6	Required Forms and Certifications:		
2.5.6.1	✓ Proposal Compliance Matrix	2.5.6.1	1005(E)
2.5.6.2	✓ Certification Statement	2.5.6.2	1006(E) – 1007(E)
2.5.6.3	✓ Medicaid Ownership and Disclosure Form	2.5.6.3	1008(E) – 1076(E), Att.2.5.6.3-1 through 2.5.6.3-4 , 1077(E)-1251(E)
Technical Proposal – Section 2.6			
2.6.2	Proposer Organization and Experience:		
2.6.2.1	✓ Proposer Organization	2.6.2.1	6-7, Att. 2.6.2.1-1, 8-24
2.6.2.2	✓ Proposed Staff Qualifications and Organizational Structure	2.6.2.2	25-30 Att. 2.6.2.2-1, 2.6.2.2-2, 31-39
2.6.3	Enrollee Value-Added Benefits	2.6.3	40-54
2.6.4	Population Health	2.6.4	55-66
2.6.5	Health Equity	2.6.5	67-78
2.6.6	Care Management	2.6.6	79-93
2.6.7	Case Scenarios	2.6.7	94-138
2.6.8	Network Management	2.6.8	139-148
2.6.9	Provider Support	2.6.9	149-160
2.6.10	Utilization Management	2.6.10	161-175
2.6.11	Quality	2.6.11	176-190 Att 2.6.11-5 through 2.6.11.7-3, 1252(E) – 1275(E) Att. 2.6.11.7-1 through 2.6.11.7-3 1278(E)-1280 (E)
2.6.11.6	Quality Response Template	2.6.11.6	1276(E) – 1277(E)
2.6.12	Value-Based Payment	2.6.12	191-200
2.6.13	Claims Management and Systems and Technical Requirements	2.6.13	201-210, Att. 2.6.13.1, 2.6.13.2-1 through 2.6.13.2-3 1281(E) – 1296 (E)
2.6.14	Program Integrity	2.6.14	211-220
2.6.15	Physical & Specialized Behavioral Health Integration Requirements	2.6.15	221-230
Veteran and Hudson Initiative Programs Participation – Sections 1.44 and 4.4			
4.4	Veteran and Hudson Initiatives Response	4.4	1297(E); Microsoft Excel/Flash Drive (E)

EXHIBIT A: CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT. The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. The Proposer should identify the Contact name and fill in the information below: (Print Clearly)

LaPAC Vendor Number:	0310165570
Official Contact Name:	[redacted]
E-mail Address:	
Facsimile Number with area code:	(502) 322-8678
US Mail Address:	One Galleria Boulevard, Suite 1200, Metairie, Louisiana 70001*

Proposer shall certify that the above information is true and shall grant permission to the State or Agencies to contact the above named person or otherwise verify the information provided.

By its submission of this proposal and authorized signature below, Proposer shall certify that:

1. The information contained in its response to this RFP is accurate and all copies are correct and complete.
2. Proposer shall comply with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein.
3. Proposer shall accept the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer agrees to submit any additional information requested by LDH that, in LDH's judgment, may be relevant to the Proposer's financial, legal, contractual, or other business interests as they relate to the RFP and contract.
5. Proposer does not have any financial, legal, contractual, and other business interest that will conflict in any manner or degree with the performance required under the contract.
6. Proposer does not have, nor does any of the Proposer's Material Subcontractors have, any financial, legal, contractual or other business interest in LDH's Enrollment Broker or in such vendor's subcontractors, if any.
7. Proposer acknowledges it will not be relieved of any legal obligations under any contract resulting from this RFP as a result of any contracts with subcontractors, that it shall be fully responsible for the subcontractor's performance, and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement will be in writing and will contain terms consistent with all terms and conditions of the contract.
8. Proposer acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.
9. Unless provided for in the contract, the Proposer shall not contract with any other party for any of the services provided for therein without the express prior written approval of the Department
10. Proposal shall be valid for at least ninety (90) Calendar Days from the date of proposer's signature below.

*Humana is providing a mailing address to be used during the COVID-19 pandemic. Please send any physical correspondence regarding the LDH Medicaid Managed Care Program RFP to this address: [redacted]

11. Proposer understands that if selected as the successful Proposer, he/she will have twenty (20) Calendar Days in which to complete contract negotiations and twenty (20) Calendar Days from the date of delivery of final contract in which to execute the final contract document.
12. Proposer shall certify, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in 2 CFR §200 Subpart F. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov.)
13. Proposer understands that, if selected as a contractor, the Louisiana Department of Revenue must determine that it is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the LDR. Proposer shall comply with La. R.S. 39:1624(A)(10) by providing its seven-digit LDR account number in order for tax payment compliance status to be verified.
14. Proposer further acknowledges its understanding that issuance of a tax clearance certificate by LDR is a necessary precondition to the approval of any contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to any contract without penalty and proceed with alternate arrangements, should a prospective contractor fail to resolve any identified outstanding tax compliance discrepancies with the LDR within seven (7) days of such notification.
15. Proposer certifies and agrees that the following information is correct: In preparing its response, the Proposer has considered all proposals submitted from qualified, potential subcontractors and suppliers, and has not, in the solicitation, selection, or commercial treatment of any subcontractor or supplier, refused to transact or terminated business activities, or taken other actions intended to limit commercial relations, with a person or entity that is engaging in commercial transactions in Israel or Israeli-controlled territories, with the specific intent to accomplish a boycott or divestment of Israel. Proposer also has not retaliated against any person or other entity for reporting such refusal, termination, or commercially limiting actions. The State reserves the right to reject the response of the Proposer if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response.
16. Proposer certifies that its proposal was independently arrived at without collusion.

Signature of Proposer or Authorized Representative:	J. E Barger, III
Typed or Printed Name:	John E. Barger, III
Date:	9/1/2021
Title:	Senior Vice President, Medicaid President
Company Name:	Humana Health Benefit Plan of Louisiana, Inc.
Address:	One Galleria Boulevard, Suite 1200
City:	Metairie
State:	Louisiana
Zip:	70001

2.5.6 Required Forms and Certifications

2.5.6.3 Exhibit D, Medicaid Ownership and Disclosure Form

Attachment 2.5.6.3-1 HHBPLA Open or Pending Healthcare Court Cases

Attachment 2.5.6.3-2 HHBPLA Supporting Documentation for Pending Healthcare Court Case

Attachment 2.5.6.3-3 HIC Open or Pending Healthcare Court Cases

Attachment 2.5.6.3-4 HIC Pending Healthcare Case Documentation

(Provided Electronically)

Exhibit D

Instructions for Louisiana Medicaid Ownership Disclosure Information Entity/Business

This is a multi-page form. Please review the instructions in their entirety before completing the form. ***Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.***

Refer to the web sites listed on the previous pages for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Enter your Provider Name at the top of each page in the space provided.

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number, if known. If this application is for a new Medicaid provider number, leave this field blank.
Taxpayer ID Number – Enter the nine (9) digit Tax ID number for this provider.
National Provider Identifier (NPI) – Enter your ten (10) digit National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Update to Current Enrollment, Re-Validation, Re-Enrollment or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.
Provider Type – Enter the Louisiana Medicaid Provider Type for this Entity/Business.
Primary Telephone Number(s) of Disclosing Entity/Business - Enter the area code and telephone number(s) at the street address of this Entity/Business.
Doing Business As (DBA) Name – Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the Entity/Business license.
Legal Name of Disclosing Entity/Business – Enter the legal name of the Entity/Business in the space labeled "Legal Name of Entity/Business."
Primary Disclosing Entity/Business Street Address, City, State, Zip - Enter the physical business street address of the Entity/Business requesting enrollment. Enter the city, state and zip code of the physical business street address.
Primary Disclosing Entity/Business Mailing Address/PO Box, City, State, Zip – Enter the mailing address or PO Box of the Entity/Business requesting enrollment. Enter the city, state and zip code of the mailing address.
Additional Post Office Boxes Not Identified Above – Enter any additional Post Office Boxes for the Entity/Business that are stand-alone or not associated with any business location.
Disclosing Entity/Business Telephone Number to Request Medical Records – Enter the area code and telephone number(s) that the Entity/Business uses to answer requests for medical records.
Disclosing Entity/Business Primary Fax Number – Enter the area code and fax number(s) of this Entity/Business.
Email Address of Entity/Business contact person - Enter the email address of the contact person who should receive official LDH notices.
Entity/Business Website – Enter the web address of the Entity/Business website if applicable.

A. **Is there a Corporate Office location for the disclosing Entity/Business?** Check the appropriate box.
DBA Name of Corporate Office – If the Entity/Business does have a corporate office location, enter the DBA Name of that office.
Corporate Office contact information – Enter the street address, mailing address/PO Box, additional PO boxes, phone number, fax number and email address for the corporate office.

B. **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below. Lists are not acceptable.
DBA Name of Additional Location – Enter the DBA name of the additional practice location.
Medicaid Provider # - Enter the Medicaid Provider number of the additional practice, if applicable.
Additional Location contact information – Enter the mailing address/PO Box, street address, additional PO boxes, phone number, fax number and email address for the additional location office. Continue identifying additional locations and the contact information in the spaces provided. If needed, please attach additional sheets if there are more than three additional locations.

C. **Identify how this disclosing Entity/Business is registered with the Internal Revenue Service – Select only 1 of the categories.** Multiple selections may result in a rejection for clarification.
Privately owned or Non-profit Providers Only – Identify the type of Entity/Business as it is registered with the Internal Revenue Service (IRS). Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of Entity/Business in the space(s) provided. Optional: May add comments in the space provided. Continue to Section II.
OR
Louisiana Government Providers Only – Identify the type of Entity/Business if Louisiana government owned. Select only one from among City and/or Parish, Department of Children and Family Services (DCFS), Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Villa, Other LDH agency, Local Education Agency (LEA), Louisiana State University (LSU), or Other State-owned entity. Check the appropriate box and complete the applicable fields.

D. **Is this disclosing Entity/Business publicly traded?** A publicly traded company is one which is traded on the open market, also called publicly held or public company. Check the appropriate box.

E. **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?** Check the appropriate box. If yes, list all names and Tax IDs in the spaces provided. Attach additional pages if needed.

SECTION II – ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

A. **Has this Entity/Business (since its existence) AND any entity/business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, 1) provide a written statement including the details on all occurrences and 2) attach all official legal documents, including any reinstatements.

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name (including maiden name and hyphenated last name if applicable), social security number, date of birth, and job title. Check one box to identify whether the person completing the form is staff, owner, third party/independent agent, or other. If you check other, please specify by writing the relationship in the space provided. List the Entity/Business address, Entity/Business telephone number, and the Entity/Business email address of the person completing this form. Finally, enter any additional Entity/Business telephone number(s) and Entity/Business email address(es).

SECTION V – OWNERSHIP INFORMATION

Medicaid requires that an Entity/Business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this Entity/Business. A separate form, Section V(b), is required for each owner, therefore, please make the necessary copies as a list of owners will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Owners are individuals and/or organizations having direct, indirect, or controlling ownership interest in this disclosing Entity/Business.

- Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing Entity/Business.
- Indirect ownership is defined as an ownership interest in an Entity/Business that has direct or indirect ownership in this disclosing Entity/Business.
- Controlling interest is defined as having operational direction or management or the ability and authorization:
    - To amend or change the corporate identity.
    - To nominate or name members of the board, directors, or trustees
    - To amend or change the bylaws, constitution, or other operating or management direction
    - To control the sale of any or all of the assets or property upon dissolution of the Entity/Business.
    - To dissolve or transfer this disclosing Entity/Business to new ownership or control.
    - Et cetera.

Owners may also be individuals associated with the Entity/Business:

- Whose personal assets are used to satisfy the Entity/Business creditors.
- Who join together to carry on an Entity/Business and expect to share in the profits and losses of the Entity/Business.
- Who report their share of profits and losses of the Entity/Business on their own personal tax returns.
- Who own corporate stock.
- Who are policy makers.
- Who have veto powers.
- Who have voting power.
- Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION V(a) – INFORMATION ON ALL OWNERS

NEW FORMAT! Please read these directions in detail.

A. **Individuals & Entities/Businesses with Direct Ownership** –List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/ or controlling interest of 5% or greater in the disclosing Entity/Business. Add additional pages if needed.
NOTE: Section V(b) must be completed for each individual listed. Item B and Section V(c) must be completed for each entity/business listed.

B. **Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business** –
First column: List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business in the first column. The disclosing Entity/Business cannot list itself as an owner.
Second column: Name all owners of the entity/business listed in the first column.
Third column: Indicate the percent of ownership each owner has in the entity/business in the first column.
Fourth column: Indicate the percent ownership each owner has in the disclosing Entity/Business. This percent of indirect ownership in the disclosing Entity/Business is determined by multiplying the percentages of ownership in e

ach entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.
Add additional pages if needed.
NOTE: Section V(c) must be completed for each Entity/Business listed and Section V(b) must be completed for each individual listed.

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

An entire Section V(b) (consisting of two pages) must be completed for **each and every individual owner named in Section V(a)**, whether the individual owns a direct or indirect stake in the disclosing Entity/Business. A list of all owners will not be accepted. **Make a copy of the blank form for each owner you report before you fill it out the first time.** For example, if you have five owners, you need to submit five completed Section V(b) forms.

A. **Individual Owner Information** – Enter the First Name, Middle Name, Maiden Name, Last Name and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Title/Job Position within this Entity/Business, the percentage of ownership of the Entity/Business, the Social Security Number (required), date of birth, current mailing address and physical address, telephone number and email address of the owner in the spaces provided.

B. **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?** – Read the question carefully and check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this owner a U.S. citizen?** Check the appropriate box. If no, provide the Alien Verification number.

D. **Does this owner reside outside the State of Louisiana?** – Check the appropriate box. If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the appropriate box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided. Attach additional pages if needed.

E. **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related (e.g. spouse, parent, child, sibling) in the spaces provided. Attach additional pages if needed.

F. **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

G. **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business participating in a Federal/State funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

H. **Has the individual owner named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. **Entity/Business Owner Information** – Enter the Entity/Business Name, the DBA Name, the Tax ID Number, the current street address of the primary location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided.

B. **Are there any business locations in addition to the location listed above?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location. Enter the DBA Name of the additional location, the Tax ID Number, the current street address of the additional location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided. Attach additional pages if needed.

C. **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?** Check the appropriate box. If yes, list all names and Tax IDs below. Attach additional pages if needed.

D. **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

E. **Is this Entity/Business and Tax ID listed in the Section I currently enrolled in a Federal/State funded healthcare program?** If yes, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments.

F. **Has this Entity/Business (since its existence) AND any Entity/Business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with, since the inception of those programs, as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, provide a written statement including the details on all occurrences. Attach all official legal documents, including any reinstatements.

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

A separate VI(b) form is required for each agent or managing employee, therefore, please make the necessary copies as a list of all managing employees and/or agent names will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Managing employee is defined as a general manger, business manager, administrator, director, or other individual who exercises operational or manager control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.

Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Managing employee/agent
- Officer
- Trustee

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

In the first table, enter the names of each agent, member or officer who is a part of management for the disclosing Entity/Business. In the second table, enter the names of each managing employee for the disclosing Entity/Business. Select the appropriate box to indicate if the individual is also an owner. If so, list their percentage of ownership. Add additional pages if needed.

NOTE: Section VI(b) must be completed for each individual listed unless individual has already been reported in Section V.

SECTION VI(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Make a photocopy of Section VI(b) for each managing employee/agent you report.

A. **AGENT– or – MANAGING EMPLOYEE –** Check a box to specify whether the person is a Managing employee or an Agent. Enter the managing employee/agent's First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable), Title/ Job Position, Social Security Number, Date of Birth, current mailing address, current physical address, telephone number and email address in the spaces provided.

B. **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? – C**heck the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this agent or managing employee a U.S. citizen?** Check the appropriate box. If no, provide Alien Verification number.

D. **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related in the spaces provided. Attach additional pages if needed.

E. **Has the agent or managing employee named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

F. **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION VII – AUTHORIZED REPRESENTATIVES

List the individuals who are authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms. Every person listed here must be either an owner or a managing employee as disclosed in the Disclosure of Ownership forms. Check one box for each person to indicate whether the individual is an owner, a managing employee, or other (specify the title in the space provided).

Printed Name of Authorized Representative – print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.
Title/Position of Authorized Representative – indicate the Authorized Representative's relationship to the entity or business (e.g., owner, administrator, agent, managing employee, billing manager, etc.).
Signature of Authorized Representative – the authorized representative must sign the form. Signatures must be original and in blue ink (stamped signatures and initials are not accepted). Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.
Date of Signature – enter the date this agreement was signed.

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date. Please sign in colored ink (not black).

Reference Material for Louisiana Medicaid Ownership Disclosure Information For an Entity/Business

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address**:** http://url.ie/ywri

MAPIL Louisiana R.S., Title 46:437.1-14. http://url.ie/yw45

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://url.ie/yw46

Louisiana Update January/February 2009: http://url.ie/yw47

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at www.lamedicaid.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a ï 3: http://tinyurl.com/ne58pwb

Social Security Act 1128 a: http://tinyurl.com/3lnj2z9

Provider Name: Humana Healthy Horizons in Louisiana

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – ENTITY/BUSINESS

Must be completed in its entirety. Refer to Instructions found at www.lamedicaid.com

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number (Leave blank if applying for new number)							

Taxpayer ID Number	7	2	1	2	7	9	2	3	5

National Provider Identifier (NPI)	1	4	2	7	5	1	1	5	8	3

This enrollment packet is for a
☒ New Enrollment ☐ Update to Current Enrollment
☐ Re-Validation ☐ Re-Enrollment

☐ Change of Ownership (CHOW) _____ (Date of CHOW) _____ (Current Medicaid Provider Number)

Provider Type: Type 2

Primary Telephone Number of Disclosing Entity/Business: (502) 580-1000

Doing Business As (DBA) Name	Legal Name of Disclosing Entity/Business		
Humana Healthy Horizons in Louisiana	Humana Health Benefit Plan of Louisiana, Inc.		
Primary Disclosing Entity/Business Street Address: One Galleria Blvd, Suite 1200	City: Metairie	State: LA	Zip: 70001
Primary Disclosing Entity/Business Mailing Address/PO Box: One Galleria Blvd, Suite 1200	City: Metairie	State: LA	Zip: 70001
Additional Post Office Boxes Not Identified Above: N/A	City: N/A	State: N/A	Zip: N/A
Disclosing Entity/Business Telephone number to request medical records: (502) 580-1000	Disclosing Entity/Business Primary Fax Number: (888) 556-2128		
Email Address of Entity/Business contact person: tthompson42@humana.com	Entity/Business Website (if applicable): Humana.com		

A. ☒ Yes ☐ No Is there a Corporate Office location separate from the primary location of the disclosing Entity/Business?

If yes, complete the section below.

DBA Name of Corporate Office: Humana Inc.

Corporate Office Street Address	City	State	Zip
500 W. Main Street	Louisville	KY	40202
Corporate Office Mailing Address/PO Box: 500 W. Main Street	City: Louisville	State: KY	Zip: 40202
Additional Post Office Boxes Not Identified Above: N/A	City: N/A	State: N/A	Zip: N/A

[redacted]

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to list additional locations

B. ☐ **Yes** ■ **No** **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Lists are not acceptable.

☐ If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Medicaid Provider #, if applicable		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service

Select only one (1) – multiple selections may result in a rejection for clarification

Privately Owned or Non-profit Providers Only

☐ **Sole Proprietorship**

☐ **Partnership/Limited Liability Partnership**: How many members are identified with this partnership? _____

☒ **Corporation:** Revenue greater than or equal to $5M annually X Revenue less than $5M annually _____

In the (current) Articles of Incorporation: How many stakeholders/individual owners are identified? 1

How many Board of Director members are identified? 3

How many officers are identified? 19

☐ **Limited Liability Corporation (LLC)**

In the (current) Articles of Organization: How many members are identified? _____

How many managing employees are identified? _____

☐ **Non-profit:** How many members are appointed to the governing board? _____ (Must attach IRS verification showing the non-profit status)

Comments: _____

Louisiana Government Providers Only

☐ **CITY and/or PARISH**

☐ **DCFS**

☐ **LDH**

☐ OBH ☐ OPH
☐ OAAS ☐ OCDD
☐ Villa ☐ Other _____

☐ **LEA (Local Education Agency)**

☐ **LSU**
Hospital -_____

☐ **Other State-owned entity:** _____

D. ☐ **Yes** ☒ **No** **Is this disclosing Entity/Business publicly traded? See instructions.**

E. ☒ **Yes** ☐ **No** **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name Ochsner/Sisters of Charity Health Plan, Inc.	Tax ID 72-1279235
Name Ochsner Health Plan, Inc.	Tax ID 72-1279235
Name	Tax ID
Name	Tax ID
Name	Tax ID

Provider Name: Humana Healthy Horizons in Louisiana

SECTION II – DISCLOSING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

A. Has this Entity/Business (since its existence) – AND –

Any Entity/Business affiliated with the same Tax ID number – AND –

Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:

☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes[1] ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

1Humana Health Benefit Plan of Louisiana and its affiliates are parties to a variety of legal actions in the ordinary course of business. Humana Health Benefit Plan of Louisiana cannot predict the outcome of these lawsuits with certainty, but other than as publicly disclosed by Humana Inc. (included in any filings with the Securities and Exchange Commission under EDGAR), there is no recent or pending litigation against Humana Health Benefit Plan of Louisiana, its parent company or any of its affiliates that could reasonably be expected to impair Humana Health Benefit Plan of Louisiana's performance under this contract for managed Medicaid in Louisiana.

The opinion expressed herein is not a waiver of attorney-client privilege and may not be relied upon in any manner or used for any purpose by any other person, and may not be quoted in whole or in part, without prior written consent from Humana's legal department.

Please refer to Attachment 2.5.6.3-1 HHBPLA Open or Pending Healthcare Court Cases or a list of open or pending healthcare court cases and Attachment 2.5.6.3-2 HHBPLA Pending Healthcare Case Documentation for supporting legal documents for each occurrence. Additionally please refer to Humana Health Benefit Plan of Louisiana, Inc.'s 10K filings: Attachment 2.5.5.1-1 HHBPLA 2020 Financial Statement, Attachment 2.5.5.1-2 HHBPLA 2019 Financial Statement, and Attachment 2.5.5.2-3 HHBPLA 2018 Financial Statement.

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to item A below

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. ☒ **Yes** ☐ **No** **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, provide the details in the fields below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
HMO	Humana Health Benefit Plan of Louisiana, Inc.	72-1279235	LA	Contract # H1951

SECTION IV - PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

[redacted]

Provider Name: _Humana Healthy Horizons in Louisiana_____

NEW FORMAT! PLEASE REFER TO THE INSTRUCTIONS FOR DETAILED EXPLANTIONS!

Make a photocopy of this page if more space is needed to list owners in items A and B

SECTION V(a) – INFORMATION ON ALL OWNERS

A. Individuals & Entities/Businesses with Direct Ownership

List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/or controlling interest of 5% or greater in the disclosing Entity/Business.

*Fill out Section V(b) for each **Individual**. Fill out both item B and Section V(c) for each **Entity/Business** listed below.*

Individuals or Entities/Businesses with ownership	% of ownership
1. Humana Insurance Company	100%
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

B. Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business

List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business. Identify the owners of that Entity/Business and their % of ownership below.* The disclosing Entity/Business cannot be listed as an owner.

*Fill out Section V(b) for each **Individual** and Section V(c) for each **Entity/Business** listed below.*

Entity/Business/Organization with a direct ownership interest listed in item A	Owners of the Entity/Business identified on the left.	% of ownership in Entity/Business identified on the left	% of ownership in the disclosing Entity/Business
1. CareNetwork, Inc.	a. Humana Inc.	100%	0%
	b.		
	c.		
	d.		
2.	a.		
	b.		
	c.		
	d.		
3.	a.		
	b.		
	c.		
	d.		
4.	a.		
	b.		
	c.		
	d.		
5.	a.		
	b.		
	c.		
	d.		

*The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
N/A			N/A		

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required)	Date of Birth
		- -	/ /

Healthcare NPI (if applicable)			
Street Address	City	State	Zip Code
Mailing Address/PO Box	City	State	Zip Code

Telephone Number	Email address
- -	

B. ☐ Yes ☐ No Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☐ Yes ☐ No Is this owner a U.S. citizen? If no, provide Alien Verification _____

D. ☐ Yes ☐ No Does this owner reside outside the State of Louisiana?

☐ Yes ☐ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?
If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☐ Yes ☐ No Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: N/A

F. ☐ **Yes** ☐ **No** **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

G. ☐ **Yes** ☐ **No** **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: N/A

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
H. Has the individual owner named above (ever):	
☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION Humana Insurance Company			
DBA Name: N/A	Legal Name of Entity/Business: Humana Insurance Company	Tax ID Number (required): 39-1263473	
Entity/Business Street Address – Primary Location: 1100 Employers Boulevard	City: DePere	State: WI	Zip: 54115
Entity/Business Mailing Address/PO Box: 1100 Employers Boulevard	City: DePere	State: WI	Zip: 54115
Additional Post Office Boxes Not Identified Above: N/A	City: N/A	State:	Zip:
Telephone Number: (502) 580-1000 -	Fax Number: (888) 556-2128		
Email address of Entity/Business contact person: tthompson42@humana.com	Entity/Business Website (if applicable): Humana.com		

B. ☐ **Yes** ☒ **No** **Are there any business locations in addition to the location listed above?**

If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

C. ☒ **Yes** ☐ **No** **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name	Employers Health Insurance Company	Tax ID	39-1263473
Name	Fireman's Fund Employers Insurance Company	Tax ID	39-1263473
Name	Wisconsin Employers Insurance Company	Tax ID	39-1263473

Provider Name: __Humana Healthy Horizons in Louisiana_____

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name	Legal Name of Entity/Business	Tax ID Number (required)

Entity/Business Street Address – Primary Location	City	State	Zip
Entity/Business Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip

Telephone Number	Fax Number
( ) -	( ) -
Email address of Entity/Business contact person	Entity/Business Website (if applicable)

B. ☐ Yes ☐ No Are there any business locations in addition to the location listed above?

☐ If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

C. ☒ Yes ☐ No Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name	Classified Life Insurance Corp.	Tax ID	39-1263473
Name		Tax ID	
Name		Tax ID	

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Humana Insurance Company

D. ☒ Yes ☐ No Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name			
Availity	Jackie Hardison			
Subcontractor Address		City	State	Zip Code
5555 Gate Parkway #110		Jacksonville	FL	32256
Telephone Number	Email address			
904 - 470 - 4900	N/A			
Subcontractor Business Name	Subcontractor Business Owner Name			
BPA International, Inc. dba BPA Quality	Darci Marquardt			
Subcontractor Address	City	State	Zip Code	
900 Stewart Avenue #110	Garden City	NY	11530	
Telephone Number	Email address			
516 - 295 - 3620	N/A			
Subcontractor Business Name	Subcontractor Business Owner Name			
C3/CustomerContactChannels, Inc	Lynne Schwartz			
Subcontractor Address		City	State	Zip Code
1200 South Pine Island Road, Suite 240		Plantation	FL	33324
Telephone Number	Email address			
954 - 577- 7723	N/A			
Subcontractor Business Name	Subcontractor Business Owner Name			
Carenet HealthCare Service	David Ledvina			
Subcontractor Address		City	State	Zip Code
11845 Interstate 10W		San Antonio	TX	78230
Telephone Number	Email address			
800-809-7000 -	N/A			

E. ☒ Yes ☐ No Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
HMO	Humana Health Benefit Plan of Louisiana, Inc.	72-1279235	LA	Contract # H1951

Provider Name: __Humana Healthy Horizons in Louisiana_____

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: _Humana Insurance Company_____

D. ☒ Yes ☐ No Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?

If yes, complete the section below for each subcontractor.

Subcontractor Business Name Cognizant Technology Solutions US Corporation	Subcontractor Business Owner Name Keith Bickett			
Subcontractor Address 300 Executive Park		City Louisville	State KY	Zip Code 40207
Telephone Number 502- 891-8895	Email address N/A			
Subcontractor Business Name Conduent Inc. DBA Xerox Comm. Solutions, LLC	Subcontractor Business Owner Name Stephanie Hargis			
Subcontractor Address 2900 100ST, STE 309	City Urbandale	State IA	Zip Code 50322	
Telephone Number (515)-288-5717	Email address N/A			
Subcontractor Business Name Dentaquest	Subcontractor Business Owner Name Christy Medina			
Subcontractor Address 465 Medford Street		City Boston	State MA	Zip Code 02129
Telephone Number 786-459-0973	Email address N/A			
Subcontractor Business Name FOCUS Health	Subcontractor Business Owner Name Liz Stearman			
Subcontractor Address 10801 Starkey Road #104-101		City Seminole	State FL	Zip Code 33777
Telephone Number 866-344-7791	Email address N/A			

E. ☐ Yes ☐ No Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Humana Insurance Company

D. ☒ Yes ☐ No Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?

If yes, complete the section below for each subcontractor.

Subcontractor Business Name: Go365, LLC	Subcontractor Business Owner Name: Jennifer Eisenberg		
Subcontractor Address: 500 West Main Street	City: Louisville	State: KY	Zip Code: 40202
Telephone Number: 877-320-1235	Email address: N/A		
Subcontractor Business Name: Harris Rothenberg, International	Subcontractor Business Owner Name:		
Subcontractor Address: 500 West Main Street	City: Louisville	State: KY	Zip Code: 40202
Telephone Number: 212-753-2059	Email address: N/A		
Subcontractor Business Name: Hinduja Global Solutions Inc	Subcontractor Business Owner Name: Jackie Thomas		
Subcontractor Address: 4355 Weaver Parkway, Suite 310	City: Warrenville	State: IL	Zip Code: 60555
Telephone Number: (309) 229-2837	Email address: N/A		
Subcontractor Business Name: Humana Pharmacy Solutions, Inc.	Subcontractor Business Owner Name: Mark Malone		
Subcontractor Address: 515 West Market Street	City: Louisville	State: KY	Zip Code: 40202
Telephone Number: 502 580 1000	Email address: N/A		

E. ☐ Yes ☐ No Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Humana Insurance Company

D. ☒ **Yes** ☐ **No** **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name: Inovalon Materials	Subcontractor Business Owner Name: Darrin Conn			
Subcontractor Address: 4321 Collington Road	City: Bowie	State: MD	Zip Code: 20716	
Telephone Number: 301-809-4000	Email address: N/A			
Subcontractor Business Name: InstaMed Communications	Subcontractor Business Owner Name: Stacy Brooks			
Subcontractor Address: 1880 John F. Kennedy BLVD #12	City: Philadelphia	State: PA	Zip Code: 19103	
Telephone Number: 215-789-3680	Email address: N/A			
Subcontractor Business Name: MD Live	Subcontractor Business Owner Name: Lori Dunne/David Rosa			
Subcontractor Address: 13630 NW 8th Street, Suite 205	City: Sunrise	State: FL	Zip Code: 33325	
Telephone Number: 417-825-6186	Email address: stuttle@mdlive.com			
Subcontractor Business Name: Medhok, Inc.	Subcontractor Business Owner Name: Jodi Drozd			
Subcontractor Address: 5550 West Idlewild Avenue Suite 150	City: Tampa	State: FL	Zip Code: 33634	
Telephone Number: 888-963-3465	Email address: infor@mhk.com			

E. ☐ **Yes** ☐ **No** **Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Humana Insurance Company

D. ☒ **Yes** ☐ **No** **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name: Mid Island Group	Subcontractor Business Owner Name: Tracy Thornton			
Subcontractor Address: 77 Schmitt Blvd.	City: Farmingdale	State: NY	Zip Code: 11735	
Telephone Number: 631-293-0189	Email address: N/A			
Subcontractor Business Name: New Century Health	Subcontractor Business Owner Name: Brittany LeMaire			
Subcontractor Address: 675 Placentia Ave.	City: Brea	State: CA	Zip Code: 92821	
Telephone Number: 888-999-7713	Email address: networkOperations@NewCenturyHealth.com			
Subcontractor Business Name: New Leaf Business Solutions	Subcontractor Business Owner Name: Nancy Toomey			
Subcontractor Address: 304 Bromwick Court	City: Louisville	State: KY	Zip Code: 40243	
Telephone Number: 502-298-2848	Email address: albert@newleafbiz.com			
Subcontractor Business Name: Outcomes Incorporated	Subcontractor Business Owner Name: Mark Malone			
Subcontractor Address: 505 Market Street, Suite 200	City: West Des Moines	State: IA	Zip Code: 50266	
Telephone Number: 515-237-0001	Email address: info@outcomesMTM.com			

E. ☐ **Yes** ☐ **No** **Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Humana Insurance Company

D. ☒ Yes ☐ No Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?

If yes, complete the section below for each subcontractor.

Subcontractor Business Name: Relias	Subcontractor Business Owner Name: Nikki Thomas			
Subcontractor Address: 1010 Sync Street	City: Morrisville	State: NC	Zip Code: 27560	
Telephone Number: 877-200-0020	Email address:			
Subcontractor Business Name: Revel Health dba Icario	Subcontractor Business Owner Name: Ben Thompson			
Subcontractor Address: 123 North 3rd Street, #605	City: Minneapolis	State: MN	Zip Code: 55401	
Telephone Number: 612-235-2111	Email address: N/A			
Subcontractor Business Name: Superior Vision	Subcontractor Business Owner Name: David Dunteman			
Subcontractor Address: 881 Elkridge Landing Road, Suite 300	City: Baltimore	State: MD	Zip Code: 21090	
Telephone Number: 443-422-4744	Email address: N/A			
Subcontractor Business Name: SS&T Pharmacy Solutions (formerly Argus)	Subcontractor Business Owner Name: Mark Malone			
Subcontractor Address: 1300 Washington Street	City: Kansas City	State: MO	Zip Code: 64105	
Telephone Number: 816-435-5409	Email address: N/A			

E. ☐ Yes ☐ No Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Humana Insurance Company

D. ☒ Yes ☐ No Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?

If yes, complete the section below for each subcontractor.

Subcontractor Business Name: Sutherland Healthcare Solutions	Subcontractor Business Owner Name: Brett Wilder		
Subcontractor Address: 3111 N University Dr, Coral Springs	City: Coral Springs	State: FL	Zip Code: 33065
Telephone Number: 954-227-3258	Email address: brett.wilder@sutherlandglobal.com		
Subcontractor Business Name: Transperfect	Subcontractor Business Owner Name: Lindsey Smith		
Subcontractor Address: 3 Park Avenue 39th Floor	City: New York	State: NY	Zip Code: 10016
Telephone Number: 212-689-5555	Email address: N/A		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number: - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number: - -	Email address		

E. ☐ Yes ☐ No Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: Humana Insurance Company

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks. **F. Has this Entity/Business (since its existence) – AND –** **Any Entity/Business affiliated with the same Tax ID number – AND –** **Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:**	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes[1] ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

1 Humana Insurance Company and its affiliates are parties to a variety of legal actions in the ordinary course of business. Humana Insurance Company cannot predict the outcome of these lawsuits with certainty, but other than as publicly disclosed by Humana Inc. (included in any filings with the Securities and Exchange Commission under EDGAR), there is no recent or pending litigation against Humana Insurance Company its parent company or any of its affiliates that could reasonably be expected to impair Humana Health Benefit Plan of Louisiana's performance under this contract for managed Medicaid in Louisiana.
The opinion expressed herein is not a waiver of attorney-client privilege and may not be relied upon in any manner or used for any purpose by any other person, and may not be quoted in whole or in part, without prior written consent from Humana's legal department.
Please refer to Attachment 2.5.6.3-3 HIC Open or Pending Healthcare Court Cases for Humana Insurance Company's open or pending healthcare court cases and Attachment 2.5.6.3-4 HIC Pending Healthcare Case Documentation for the supporting documentation for each occurence.
Additionally, please refer to Humana Insurance Company's 10K filings: Attachment 2.5.5.1-4 HIC 2020 Financial Statement, Attachment 2.5.5.1-5 HIC 2019 Financial Statement, and Attachment 2.5.5.2-6 HIC 2018 Financial Statement.

Provider Name: Humana Healthy Horizons in Louisiana

*Make a photocopy of this page if more space is needed to list individuals.**

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1. Bruce Dale Broussard	☐ Yes ■ No	0
2. Susan Marie Diamond	☐ Yes ■ No	0
3. Susan Draney Schick	☐ Yes ■ No	0
4. Timothy Alan Wheatley	☐ Yes ■ No	0
5. John Edward Barger, III	☐ Yes ■ No	0
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1. Douglas Allen Edwards	☐ Yes ■ No	0
2. George Renaudin, II	☐ Yes ■ No	0
3. Steven Edward McCulley	☐ Yes ■ No	0
4. Sean Joseph O'Reilly	☐ Yes ■ No	0
5. Vanessa Marie Olson	☐ Yes ■ No	0
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1. Donald Hank Robinson	☐ Yes ■ No	0
2. Ellen Rae Sexton	☐ Yes ■ No	0
3. Cynthia Hillebrand Zipperle	☐ Yes ■ No	0
4. Alan James Bailey	☐ Yes ■ No	0
5. William Mark Preston	☐ Yes ■ No	0
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Provider Name: Humana Healthy Horizons in Louisiana

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1. Joseph Matthew Ruschell	☐ Yes ■ No	0
2. Ralph Martin Wilson	☐ Yes ■ No	0
3. Andrew Joseph Besendorf III	☐ Yes ■ No	0
4. Courtney Danielle Durall	☐ Yes ■ No	0
5.	☐ Yes ■ No	0
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Bruce	Dale		Broussard		

Title/Job Position within this Entity/Business	% ownership	[redacted]
President and Chief Executive Officer	0	

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
Same			

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Bruce Broussard

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Susan	Marie		Diamond		

Title/Job Position within this Entity/Business	% ownership
Chief Financial Officer	0

[redacted]

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Susan Marie Diamond

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Timothy	Alan		Wheatley		

Title/Job Position within this Entity/Business	% ownership
Segment President, Retail	0

[redacted]

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Timothy Alan Wheatley

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Susan	Draney		Schick		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Segment President, Group, Military and Specialty Businesses	**0**	

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Susan Schick

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
John	Edward		Barger		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Senior Vice President, Medicaid President	0	

Mailing Address/PO Box	City	State	Zip Code
4030 W Boy Scout Blvd	Tampa	FL	33607
Physical Address	**City**	**State**	**Zip Code**
4030 W Boy Scout Blvd	Tampa	FL	33607

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: John Edward Barger

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

E. Has the agent or managing employee named above (ever):

☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Douglas	Allen		Edwards		

Title/Job Position within this Entity/Business	% ownership
Senior Vice President, Workplace Experience	0

[redacted]

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Douglas Allen Edwards

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
George			Renaudin		

Title/Job Position within this Entity/Business	% ownership
Senior Vice President, Medicare Markets, Economics and Provider Experience	0

[redacted]

Mailing Address/PO Box	City	State	Zip Code
302 Seven Springs Way, Suite 200	Brentwood	TN	37037
Physical Address	**City**	**State**	**Zip Code**
302 Seven Springs Way, Suite 200	Brentwood	TN	37037

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: George Renaudin

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Steven	Edward		McCulley		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Senior Vice President, Medicare	0	

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202

Physical Address	City	State	Zip Code
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Steven Edward McCulley

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Sean	Joseph		O'Reilly		

Title/Job Position within this Entity/Business	% ownership
Senior Vice President, Enterprise Compliance and Chief Compliance Officer	0

[redacted]

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Sean Joseph O'Reilly

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Vanessa	Marie		Olson		

Title/Job Position within this Entity/Business	% ownership
Senior Vice President, Chief Actuary	0

[redacted]

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202

Physical Address	City	State	Zip Code
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Vanessa Marie Olson

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ■ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Donald	Hank		Robinson		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Senior Vice President, Tax	0	

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Donald Robinson

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Ellen	Rae		Sexton		

Title/Job Position within this Entity/Business	% ownership
Senior Vice President, Specialty	0

Mailing Address/PO Box	City	State	Zip Code
1100 Employers Blvd,	Greenbay	WI	54344
Physical Address	**City**	**State**	**Zip Code**
100 Employers Blvd,	Greenbay	WI	54344

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Ellen Sexton

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ■ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Cynthia	Ann	Hillebrand	Zipperle		

Title/Job Position within this Entity/Business	% ownership
Senior Vice President, Chief Accounting Officer & Controller	0

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202

Physical Address	City	State	Zip Code
500 West Main Street	Louisville	KY	40202

[redacted]

B. ■ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Cynthia	Ann	Hillebrand			

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Cynthia Zipperle

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ■ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Alan	James		Bailey		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Vice President and Treasurer	0	

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Alan Bailey

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
William	Mark		Preston		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Vice President, Investments	0	

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: William Preston

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Joseph	Matthew		Ruschell		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Associate Vice President, Assistant General Counsel & Corporate Secretary		

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Joseph Ruschell

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Ralph	Martin		Wilson		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Vice President	0	

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Ralph Wilson

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Andrew	Joseph		Besendorf		

Title/Job Position within this Entity/Business	% ownership	[redacted]
Appointed Actuary	0	

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Andrew Besendorf

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: Humana Healthy Horizons in Louisiana

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Courtney	Danielle		Durall		

Title/Job Position within this Entity/Business	% ownership
Assistant Corporate Secretary and Legal Advisor	0

[redacted]

Mailing Address/PO Box	City	State	Zip Code
500 West Main Street	Louisville	KY	40202
Physical Address	**City**	**State**	**Zip Code**
500 West Main Street	Louisville	KY	40202

[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: Humana Healthy Horizons in Louisiana

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Courtney Durall

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

SECTION VII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS, etc.

Note: Every person listed below must be disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1. Bruce Dale Broussard	☐ Owner ☐ Managing employee ☒ Other Officer
2. Susan Marie Diamond	☐ Owner ☐ Managing employee ☒ Other Officer
3. Susan Draney Schick	☐ Owner ☐ Managing employee ☒ Other Officer
4. Timothy Alan Wheatley	☐ Owner ☐ Managing employee ☒ Other Officer
5. John Edward Barger, III	☐ Owner ☐ Managing employee ☒ Other Officer
6. Douglas Allen Edwards	☐ Owner ☐ Managing employee ☒ Other Officer
7. George Renaudin, II	☐ Owner ☐ Managing employee ☒ Other Officer
8. Steven Edward McCulley	☐ Owner ☐ Managing employee ☒ Other Officer
9. Sean Joseph O'Reilly	☐ Owner ☐ Managing employee ☒ Other Officer
10. Vanessa Marie Olson	☐ Owner ☐ Managing employee ☒ Other Officer

Please sign in blue ink (not black)

John E. Barger, III
Printed Name of Authorized Representative


Signature of Authorized Representative
(sign in blue ink)

Senior Vice President, Medicaid President
Title/Position

9/1/2021
Date of Signature

SECTION VII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS, etc.

Note: Every person listed below must be disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1. Donald Hank Robinson	☐ Owner ☐ Managing employee ☒ Other Officer
2. Ellen Rae Sexton	☐ Owner ☐ Managing employee ☒ Other Officer
3. Cynthia Hillebrand Zipperle	☐ Owner ☐ Managing employee ☒ Other Officer
4. Alan James Bailey	☐ Owner ☐ Managing employee ☒ Other Officer
5. William Mark Preston	☐ Owner ☐ Managing employee ☒ Other Officer
6. Joseph Matthew Ruschell	☐ Owner ☐ Managing employee ☒ Other Officer
7. Ralph Martin Wilson	☐ Owner ☐ Managing employee ☒ Other Officer
8. Andrew Joseph Besendorf, III	☐ Owner ☐ Managing employee ☒ Other Officer
9. Courtney Danielle Durall	☐ Owner ☐ Managing employee ☒ Other Officer
10.	☐ Owner ☐ Managing employee ☐ Other

Please sign in blue ink (not black)

John E. Barger, III
Printed Name of Authorized Representative

Signature of Authorized Representative
(sign in blue ink)

Senior Vice President, Medicaid President
Title/Position

9/1/2021
Date of Signature

Revised 03/2018

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That the provider has disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7. That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US.
13. The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14. The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
15. The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16. The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation.
18. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

John E. Barger, III	J E Barger
Printed Name of Authorized Representative	Signature of Authorized Representative *(sign in blue ink)*
Senior Vice President, Medicaid President	9/1/2021
Title/Position of Authorized Representative	Date of Signature

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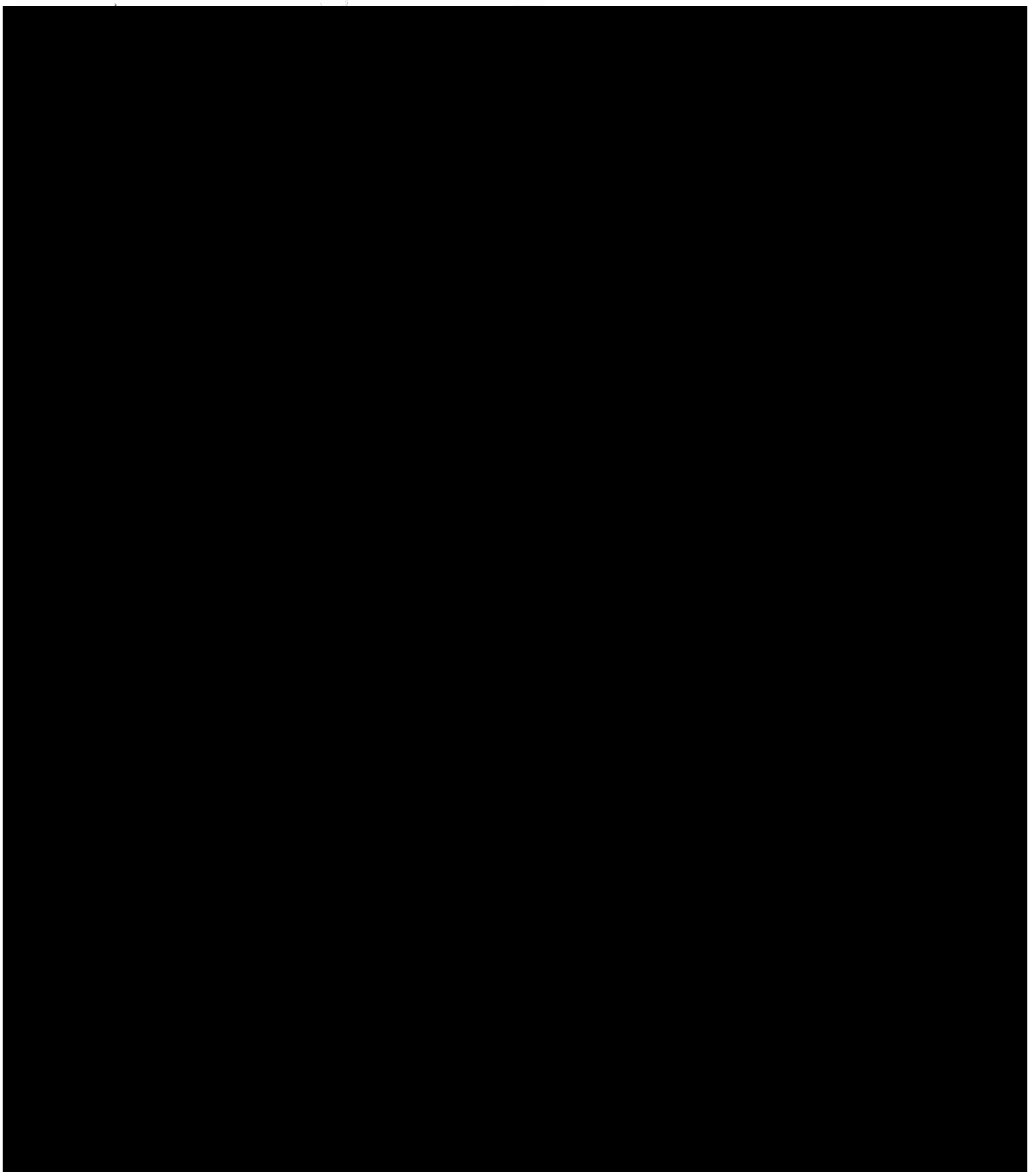
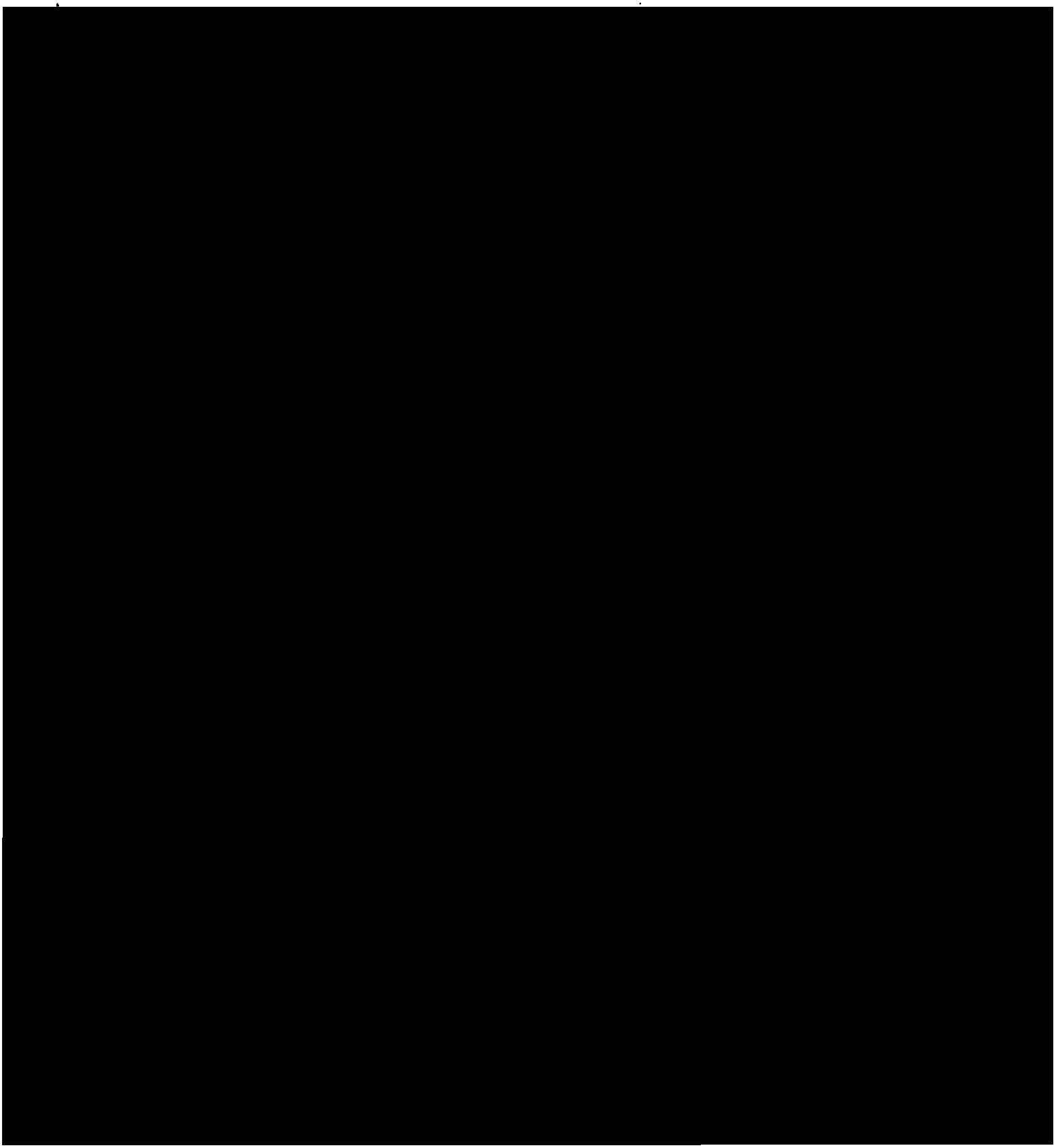
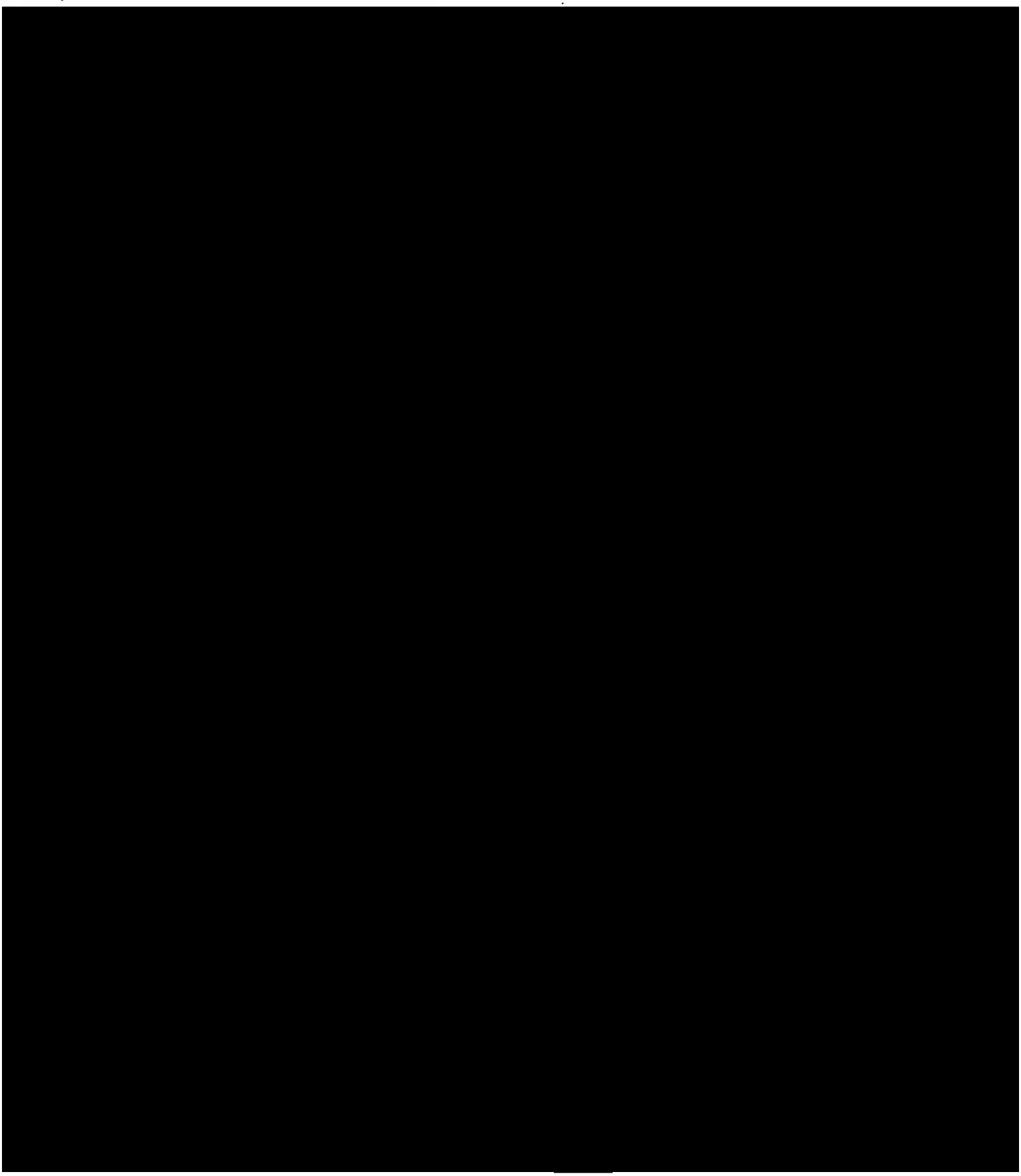
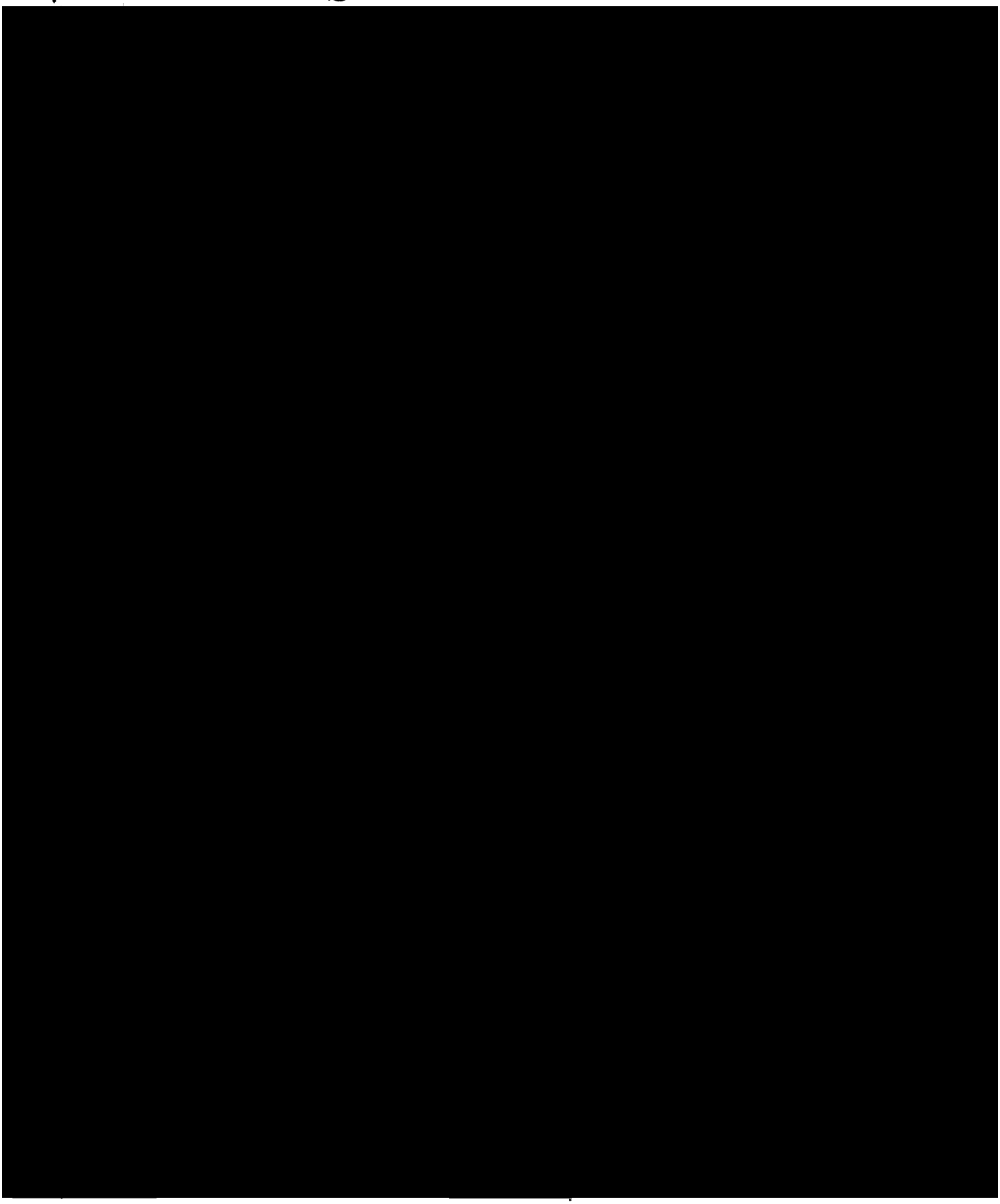
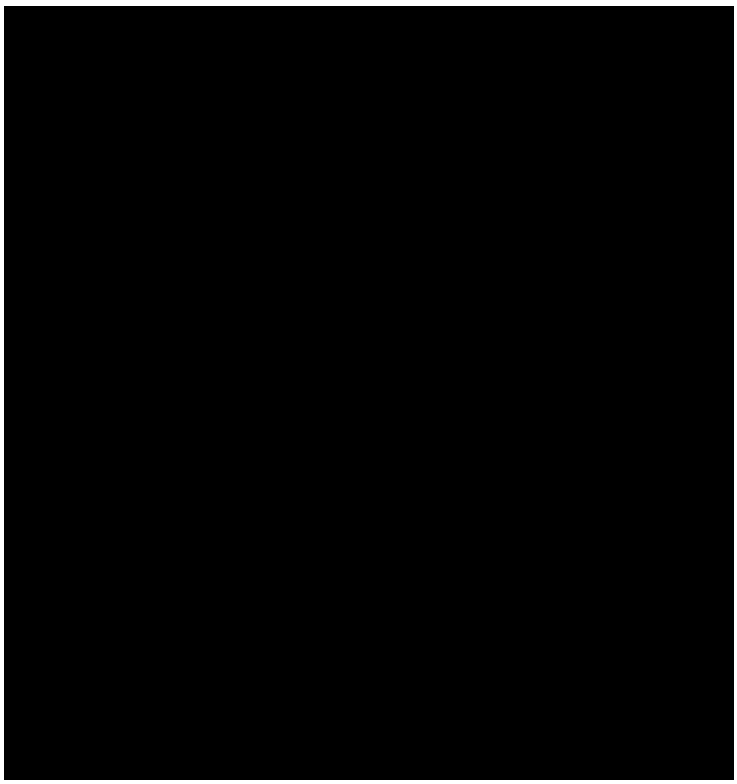
Attachment 2.5.6.3-1 HHBPLA Open or Pending Healthcare Court Cases

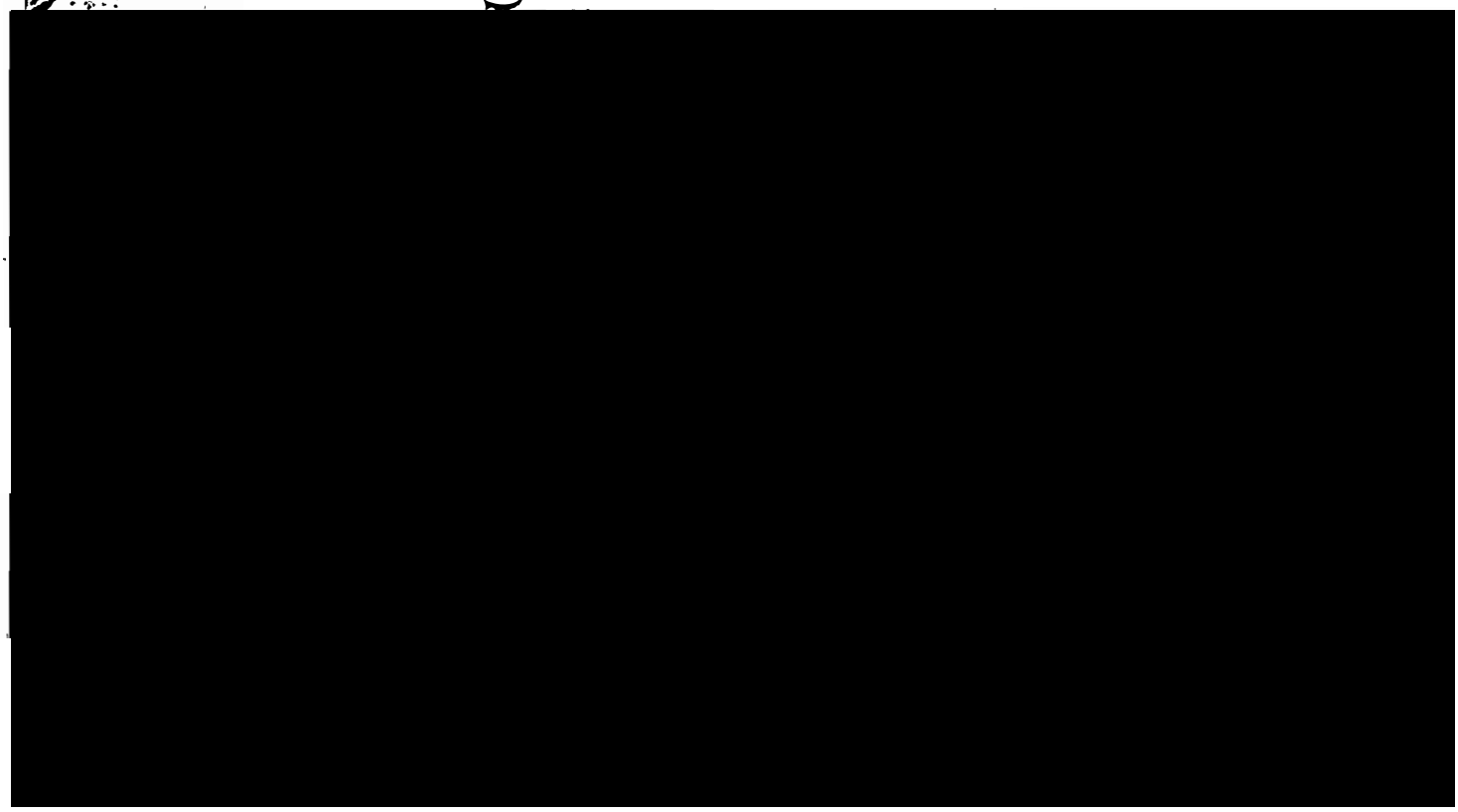


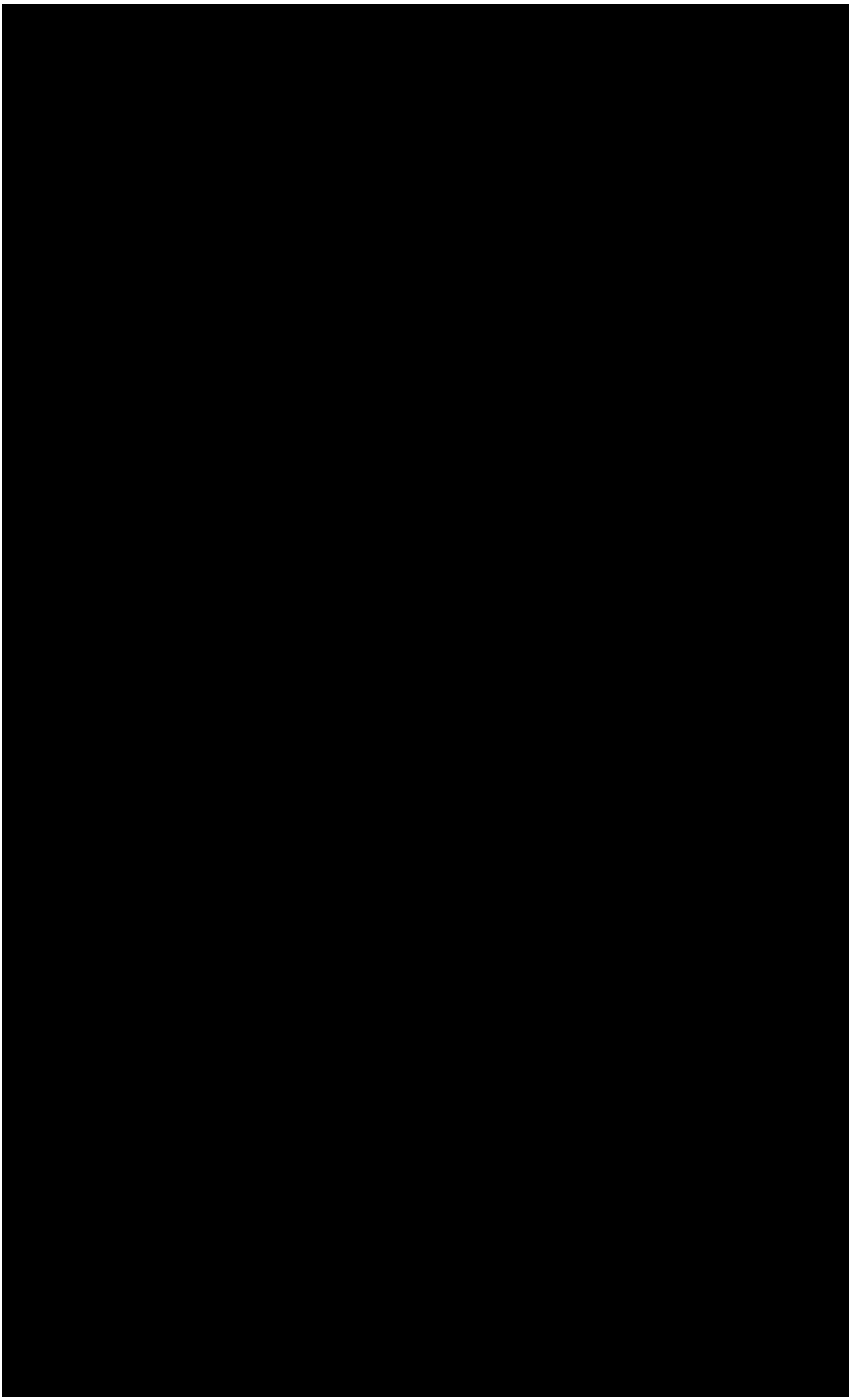




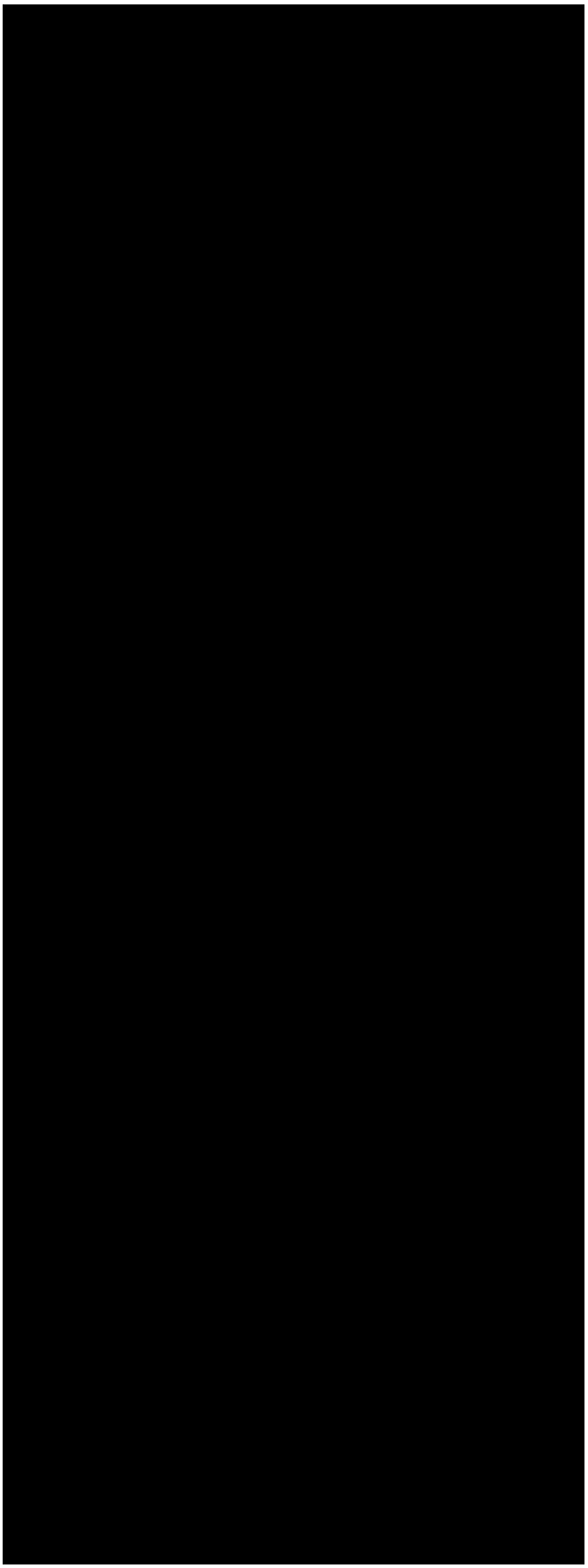








Attachment 2.5.6.3-3 HIC Open or Pending Healthcare Court Cases



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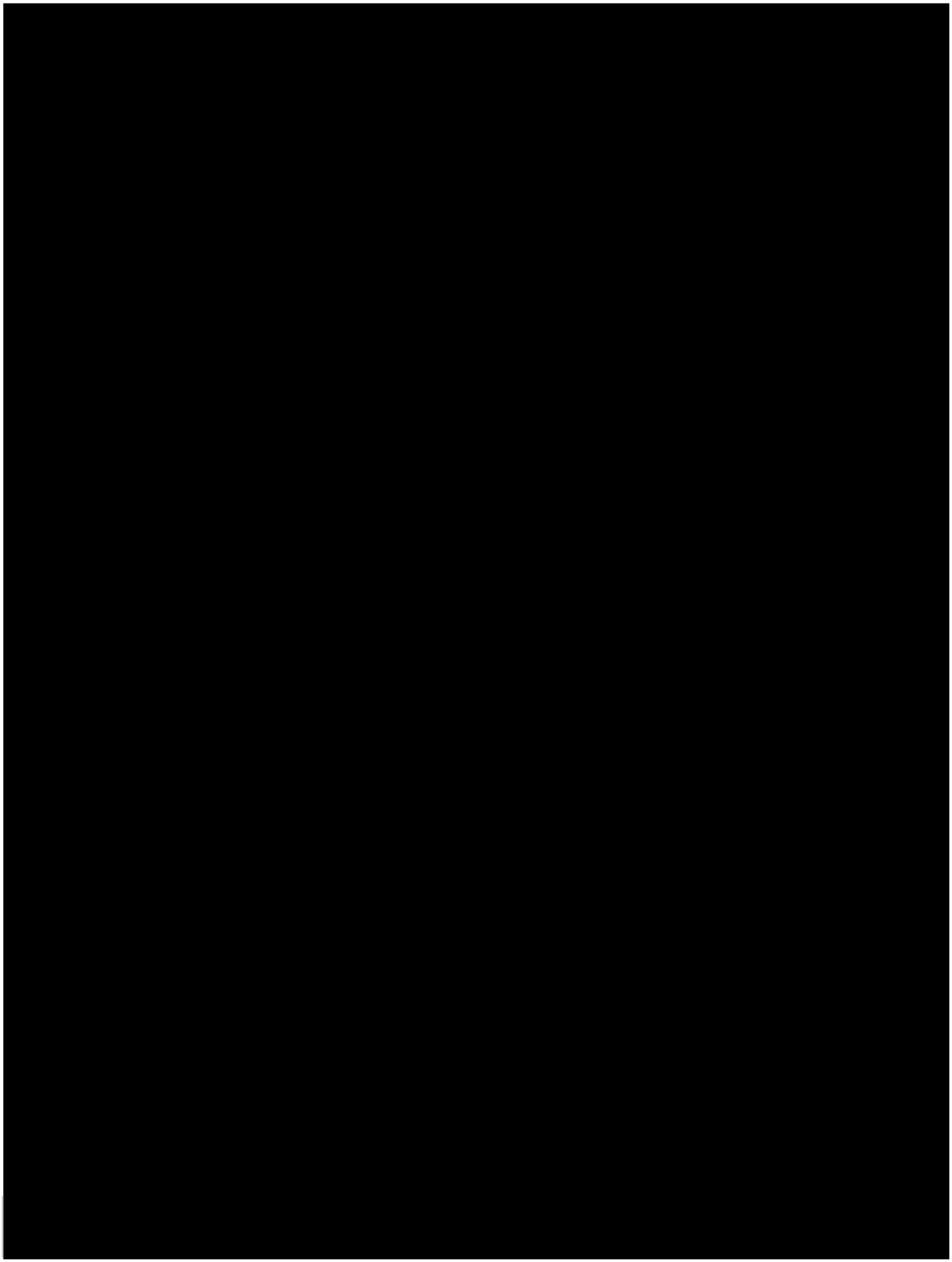

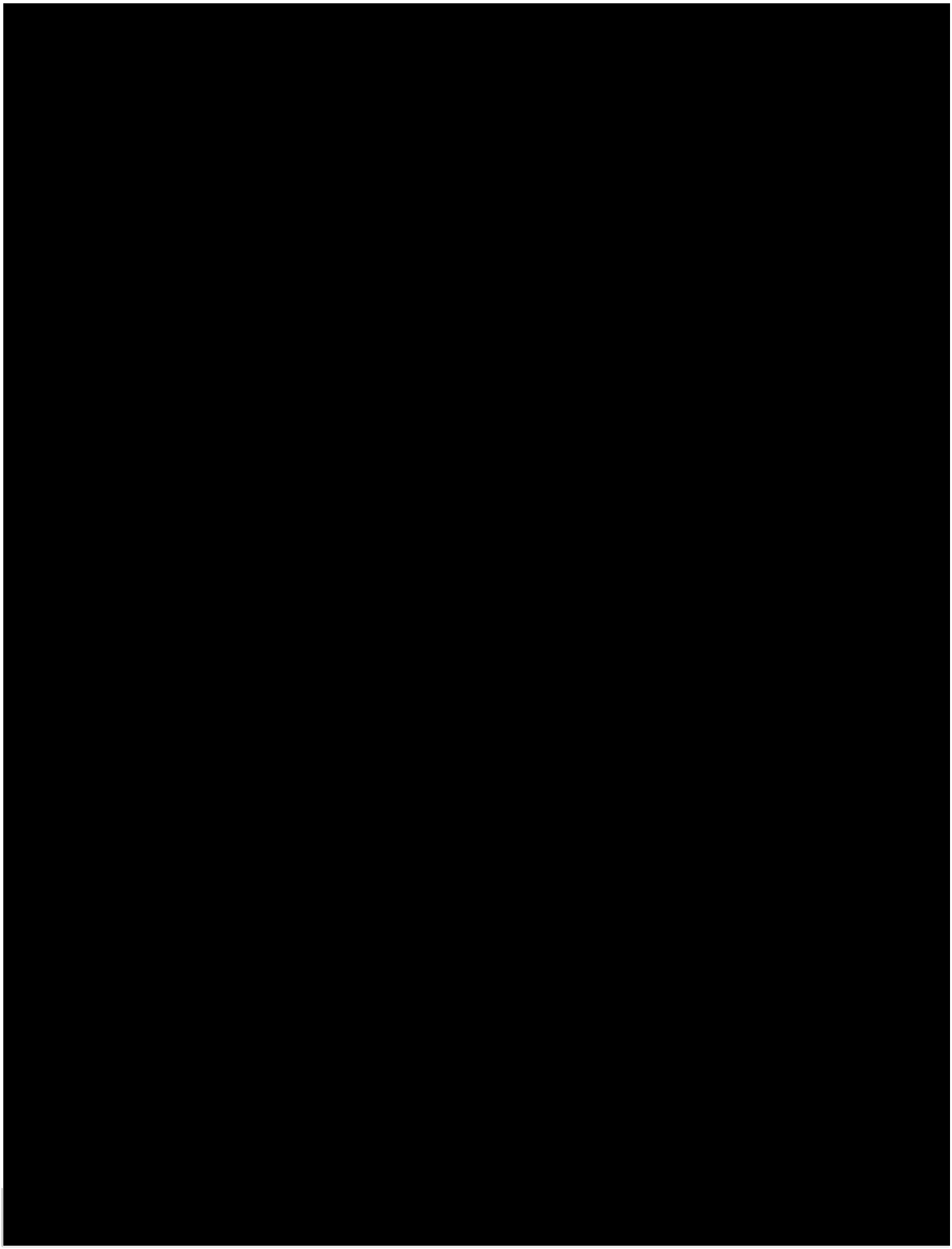

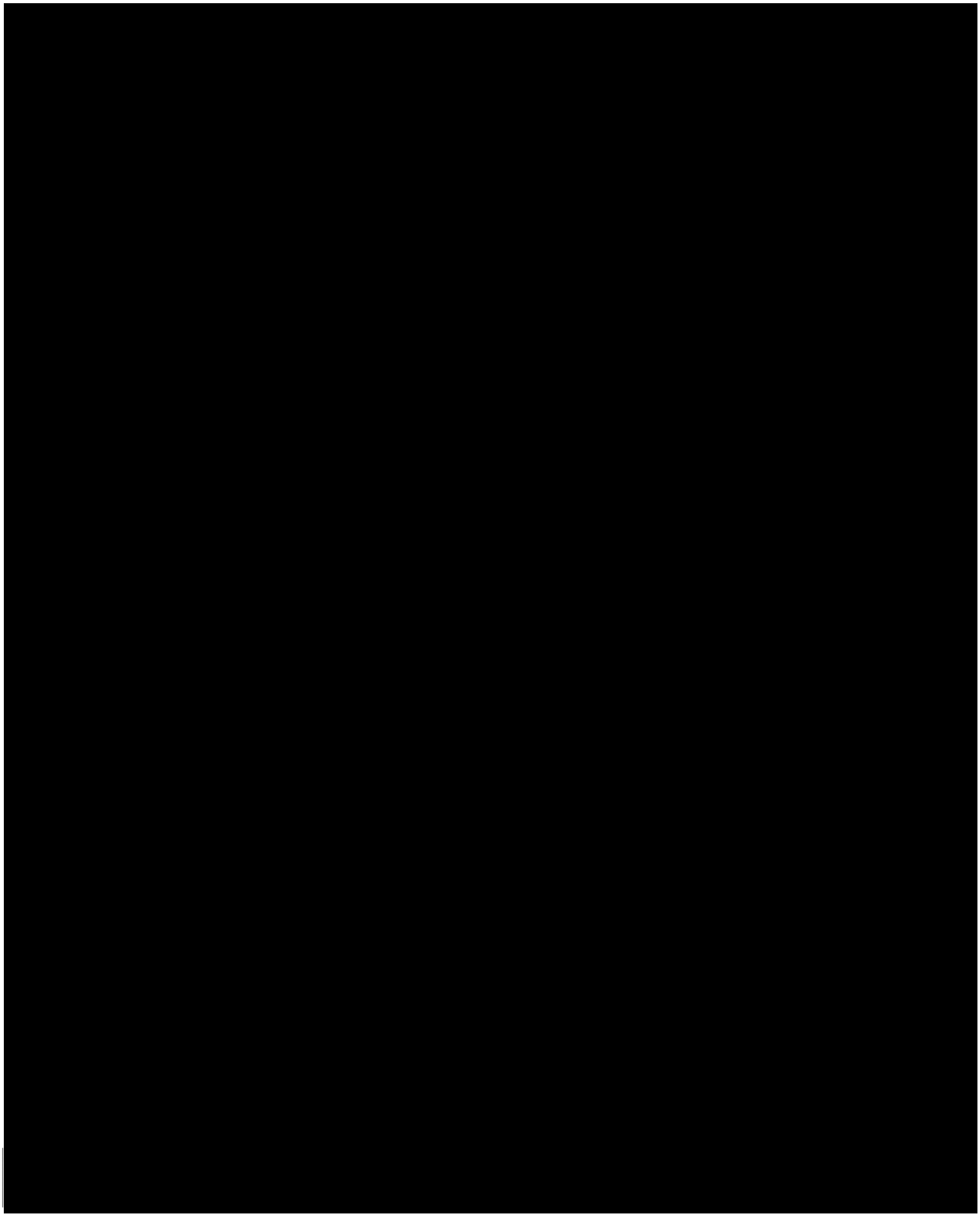

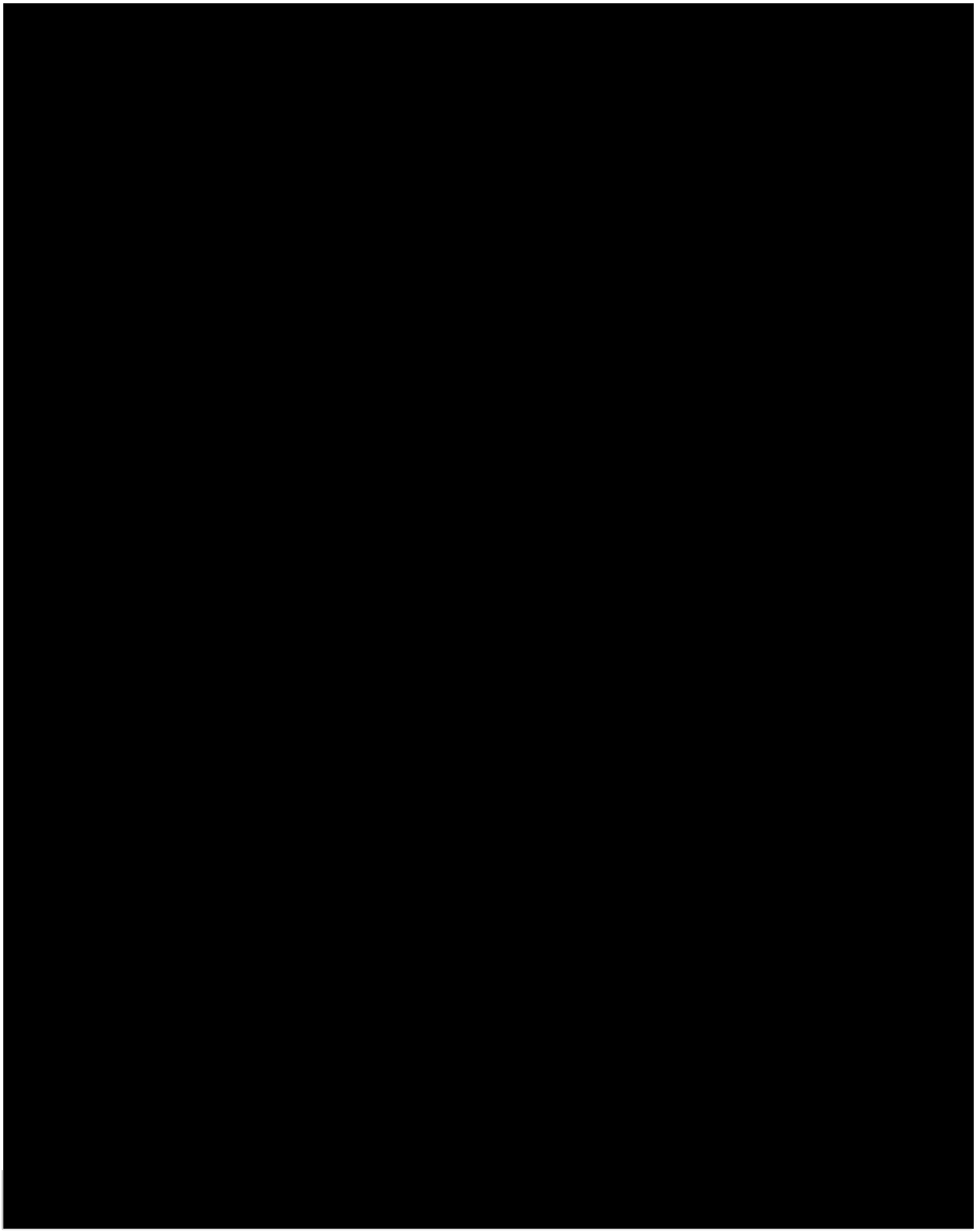

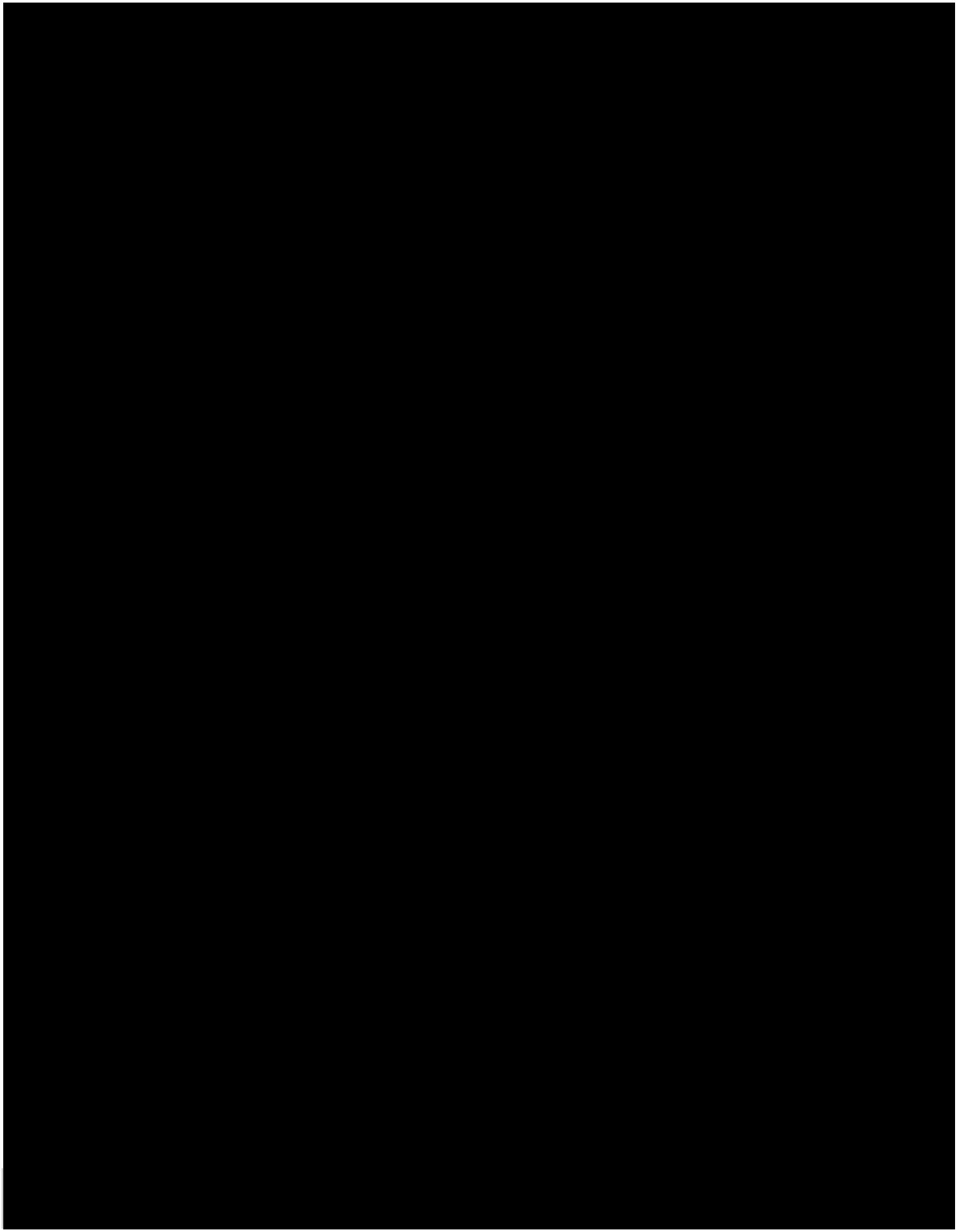

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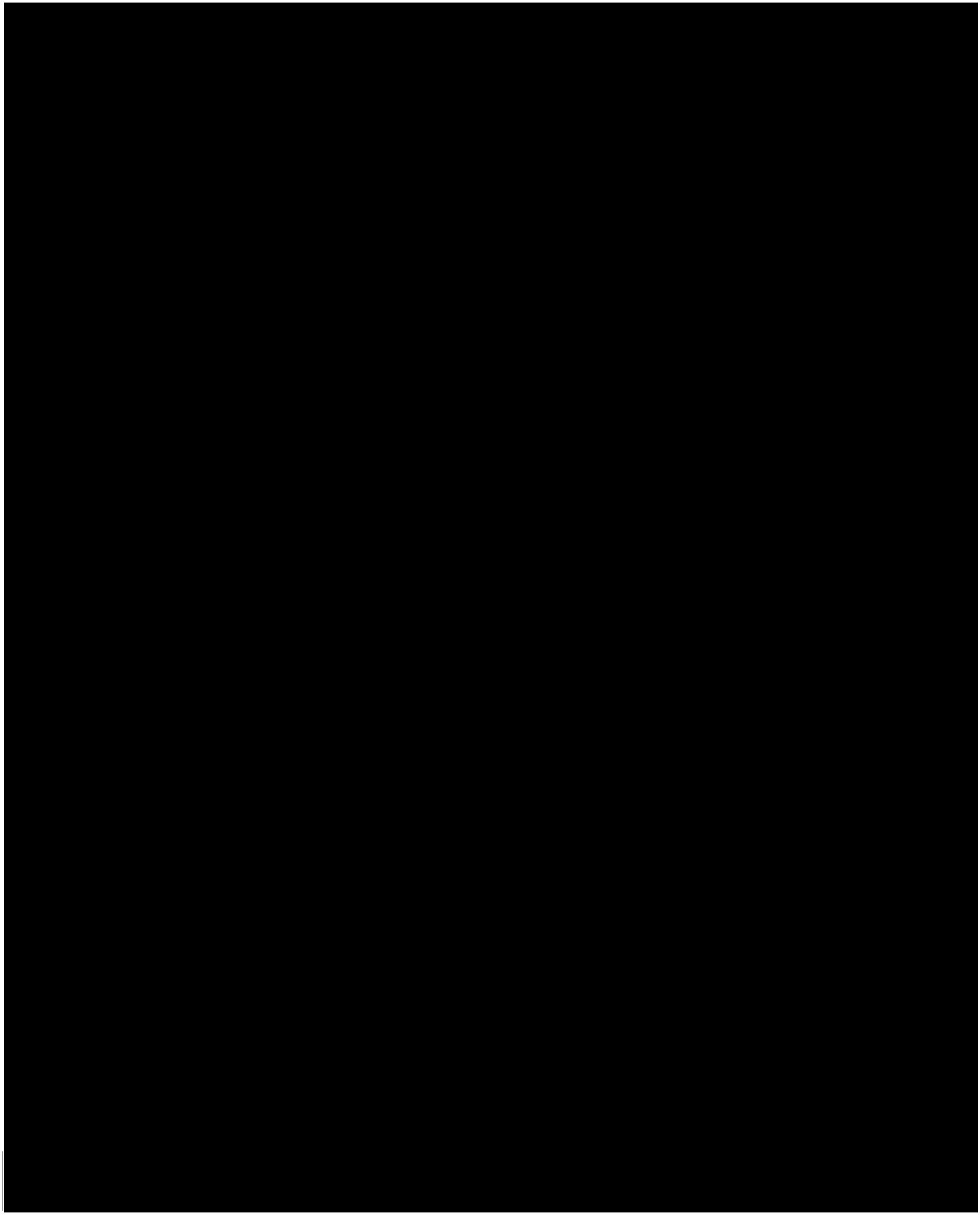

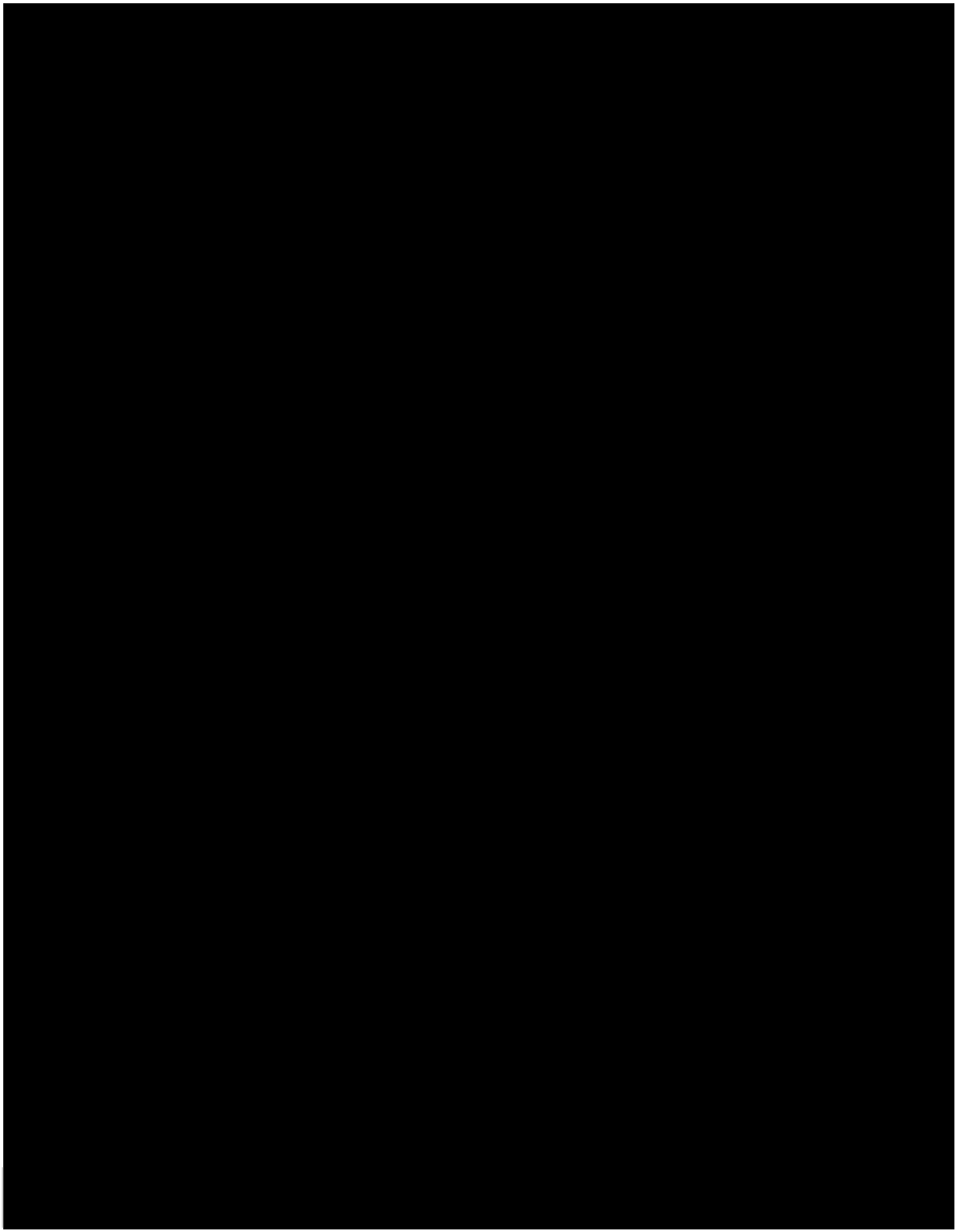

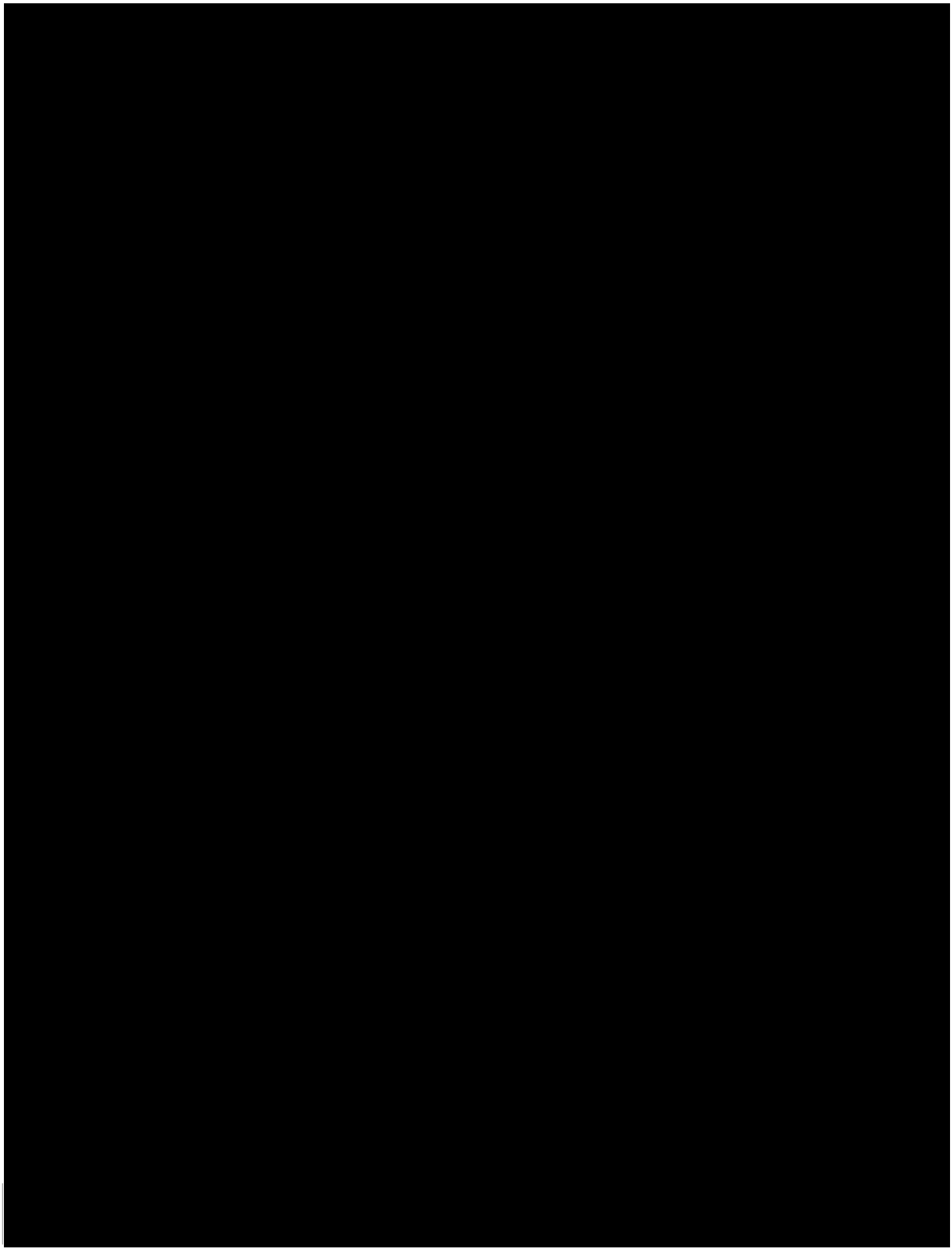

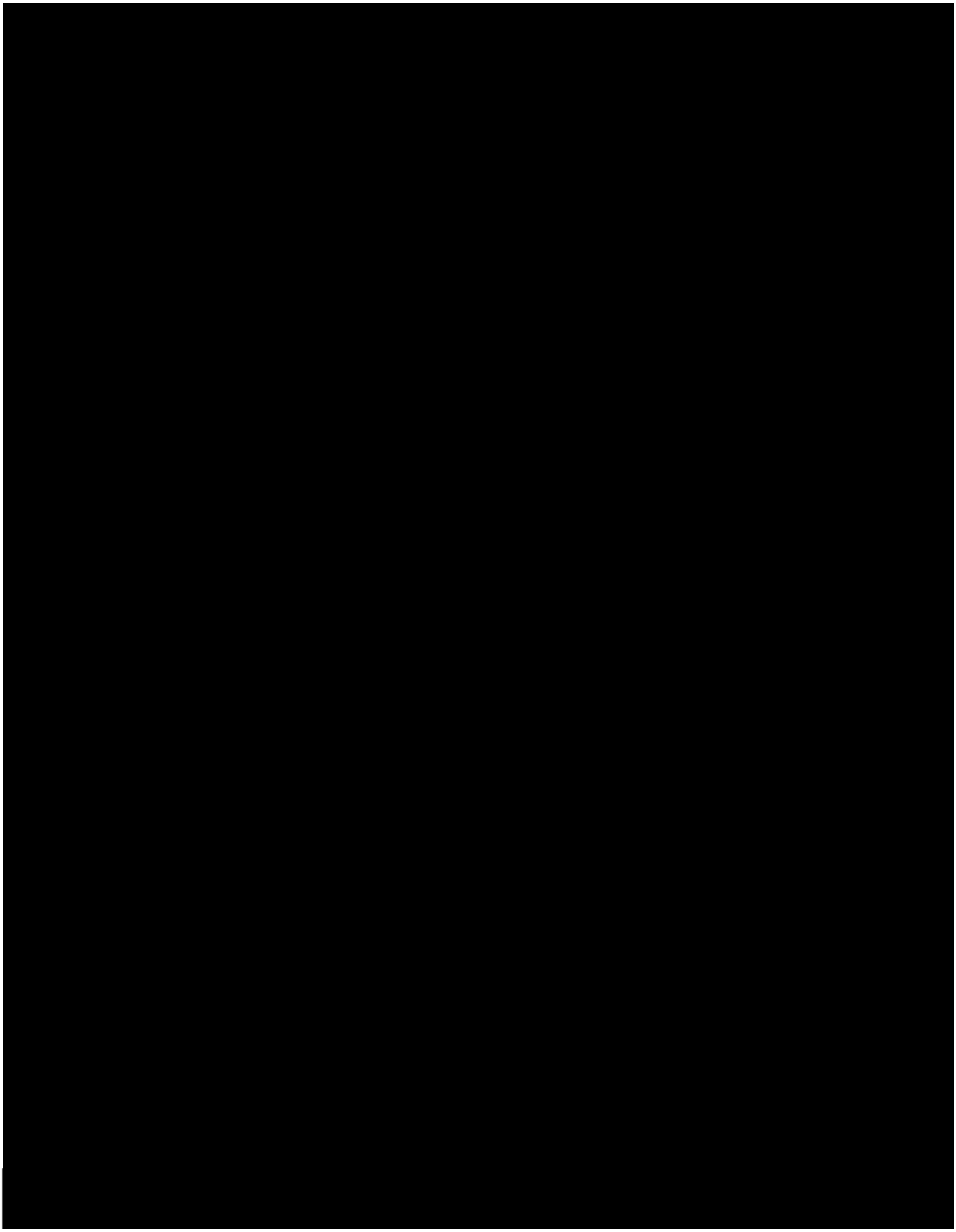

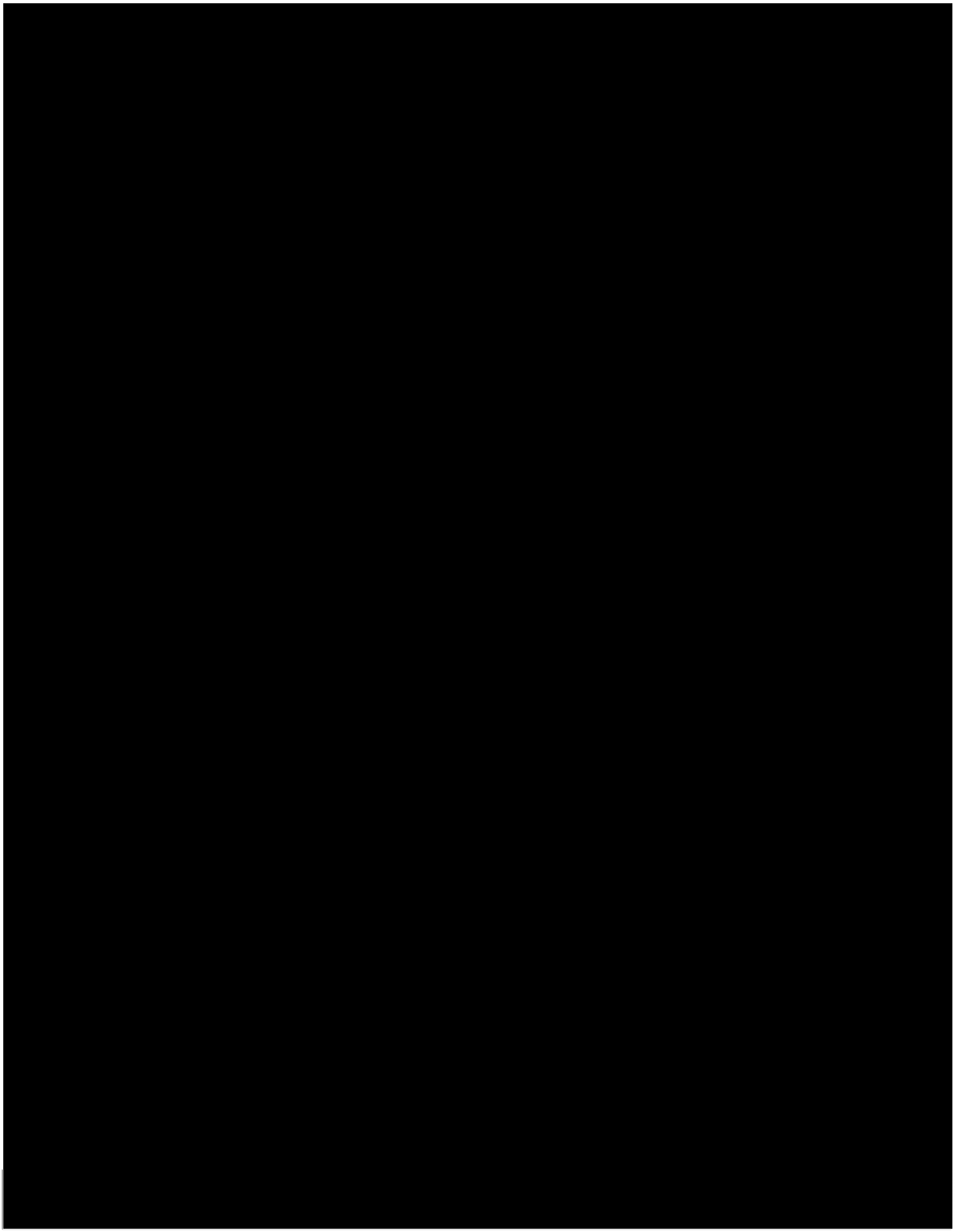

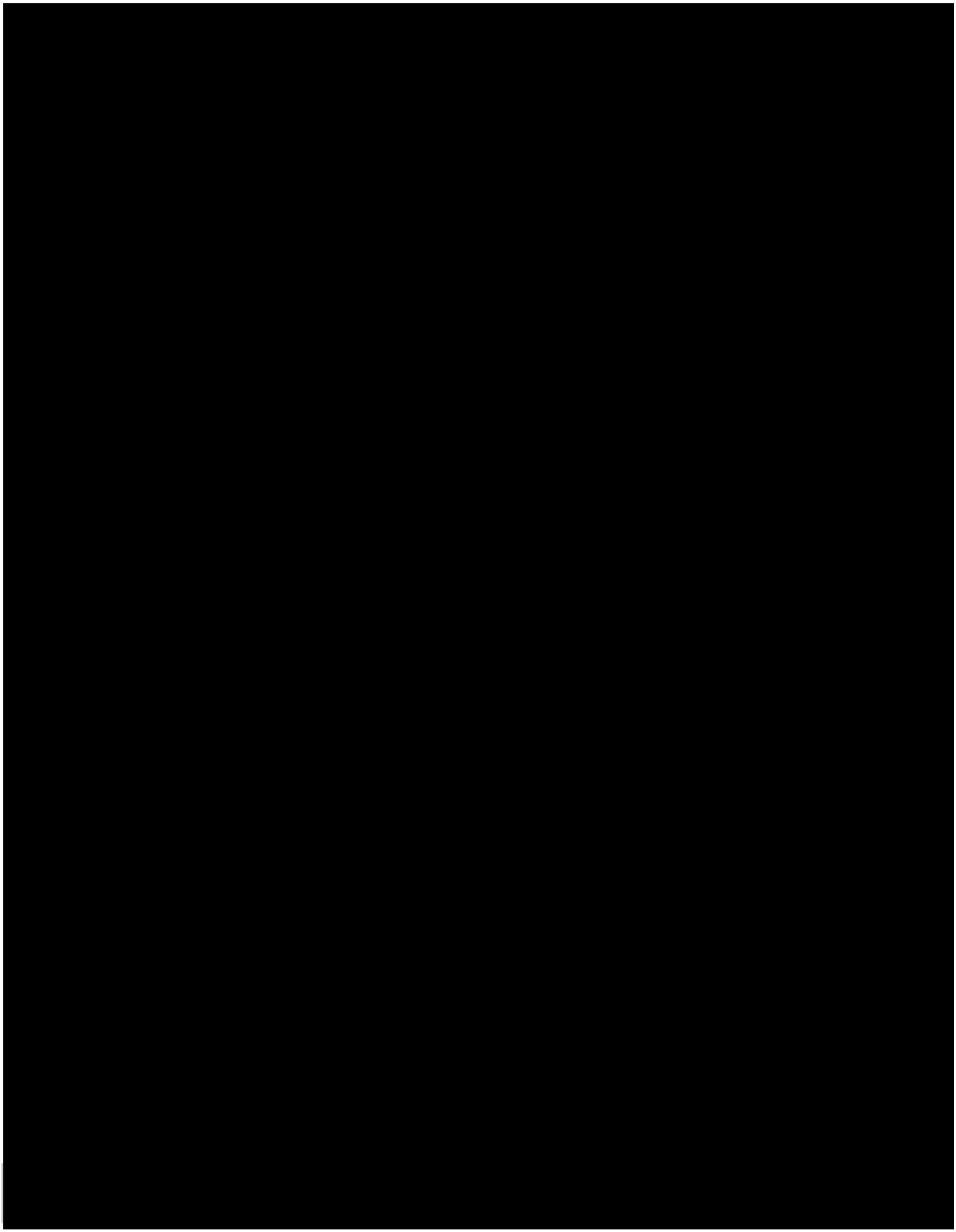

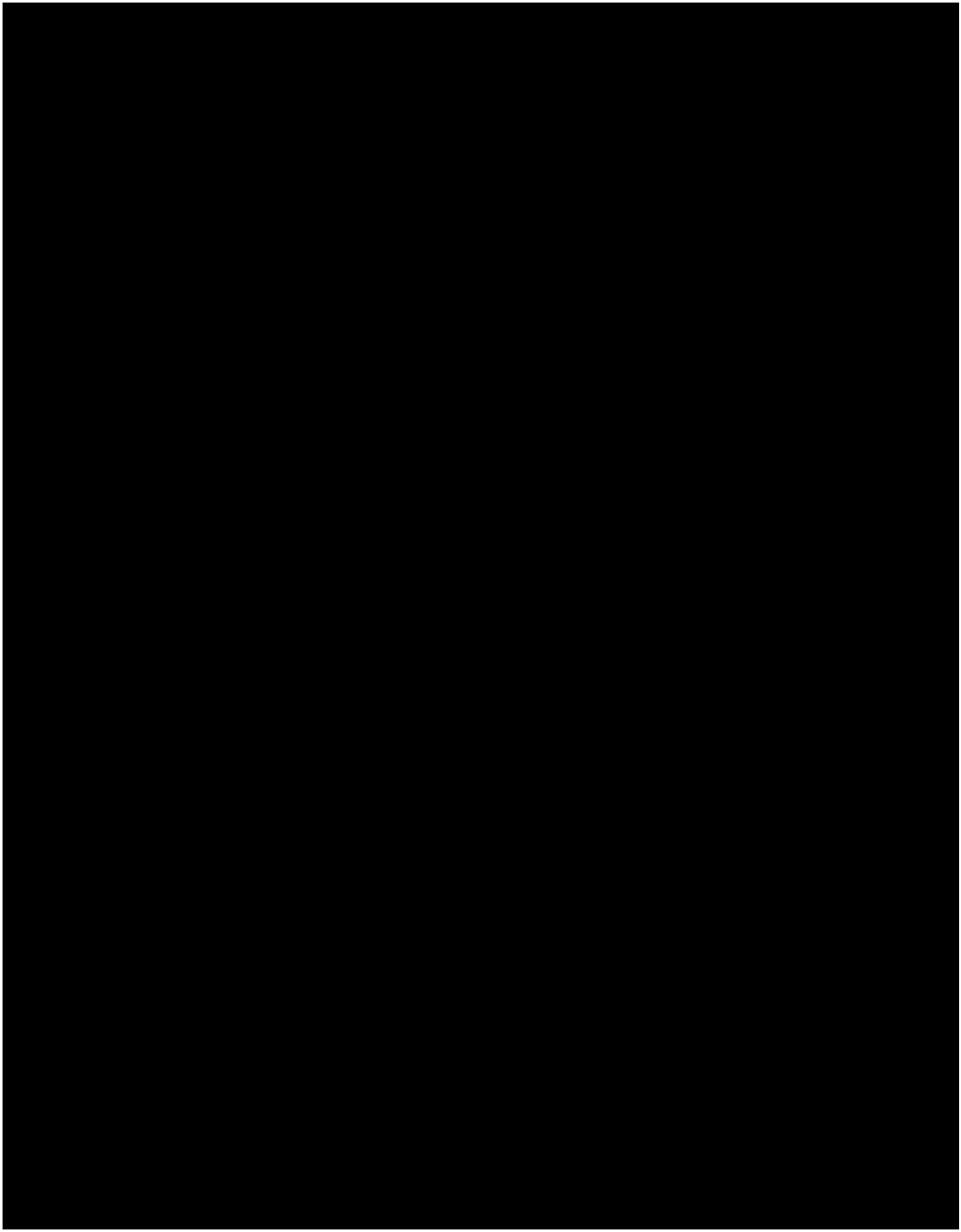

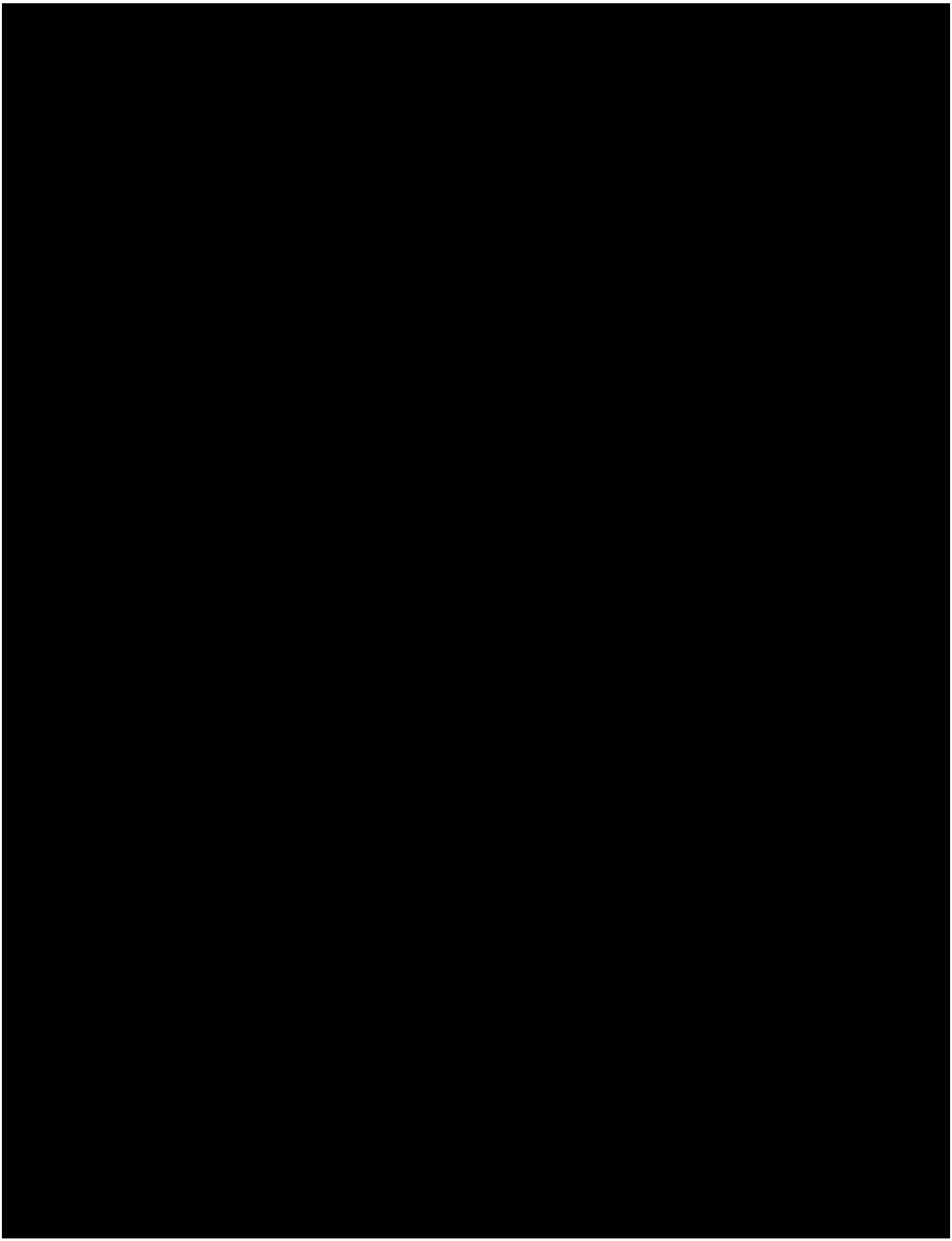

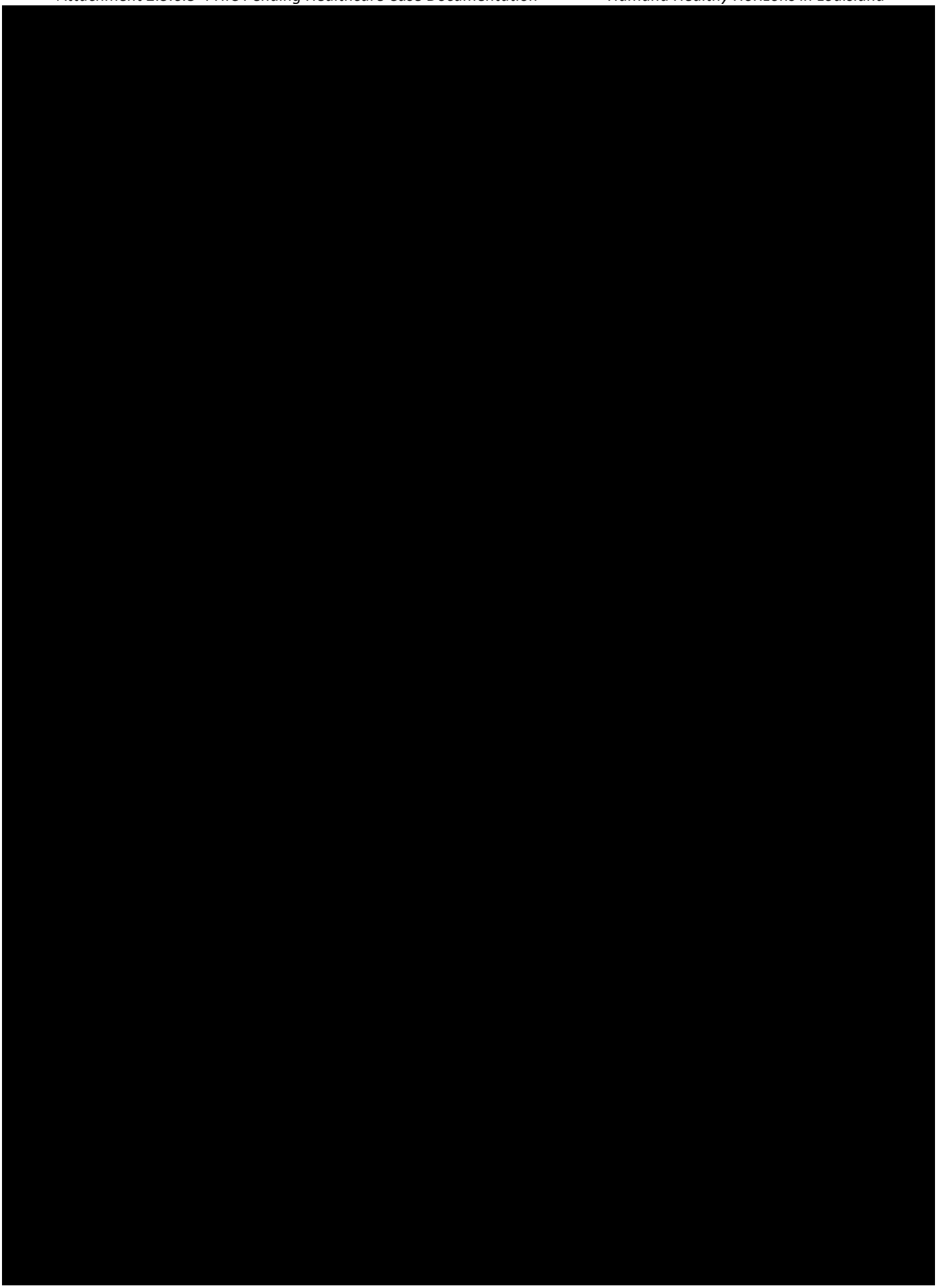

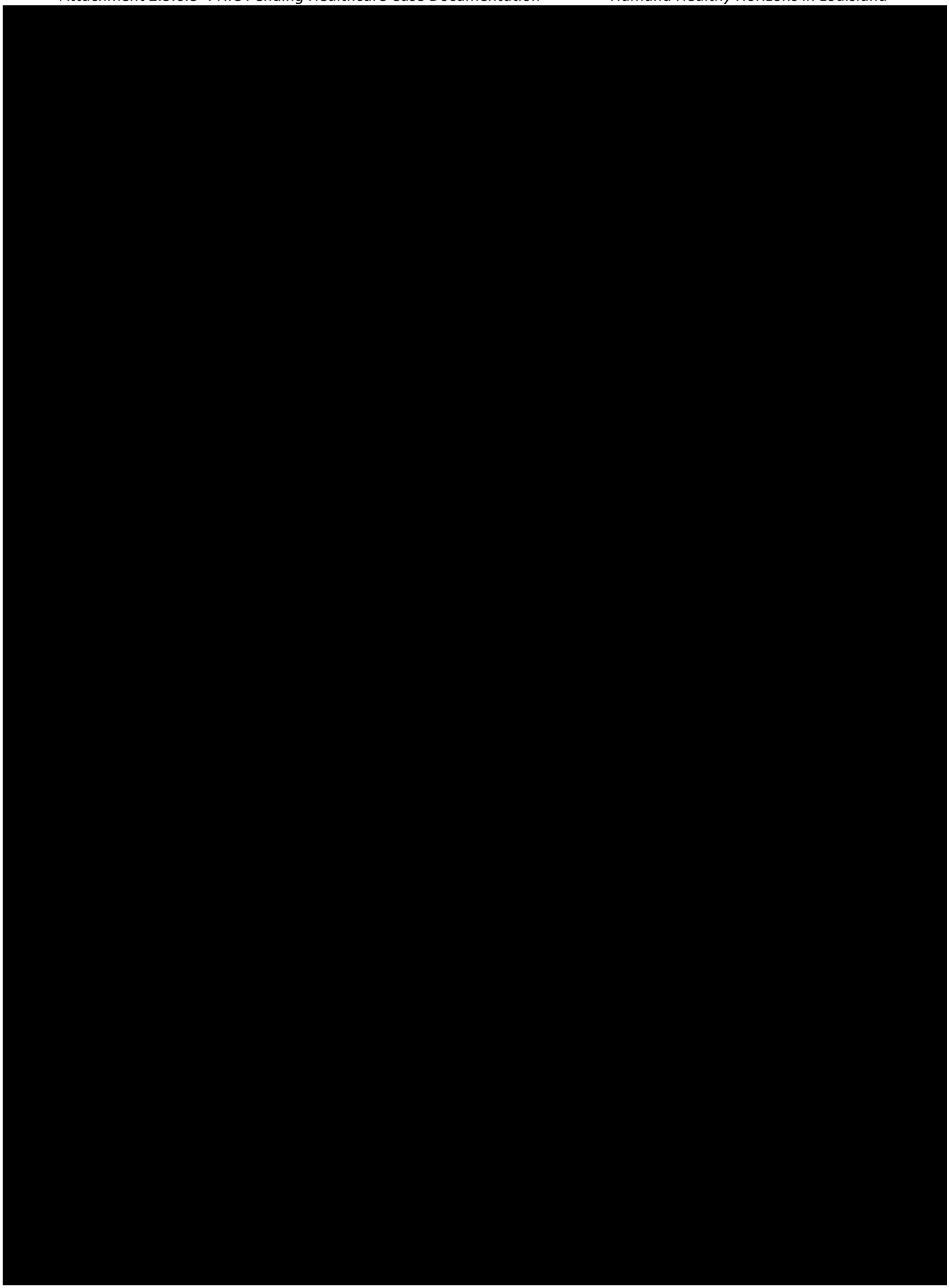

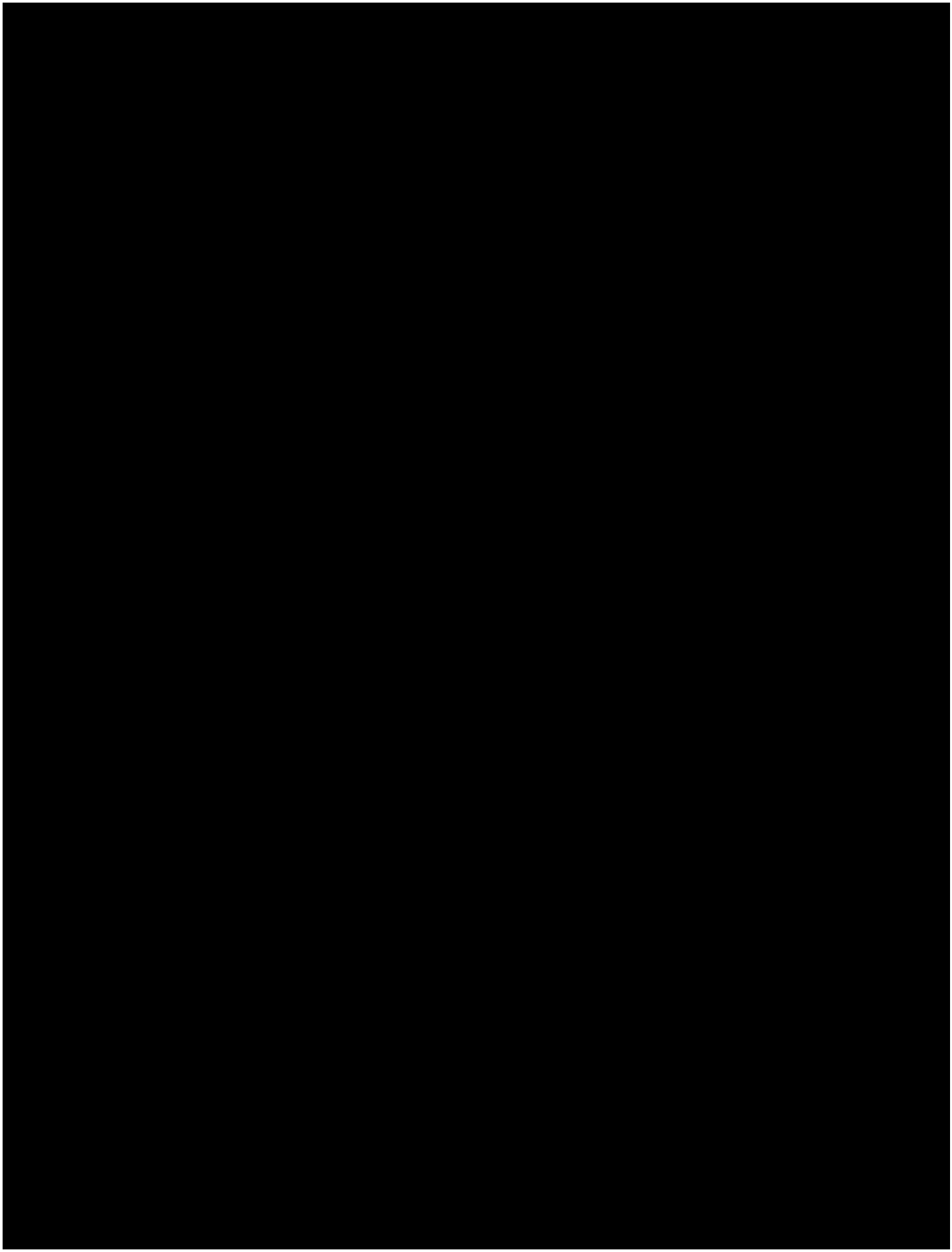

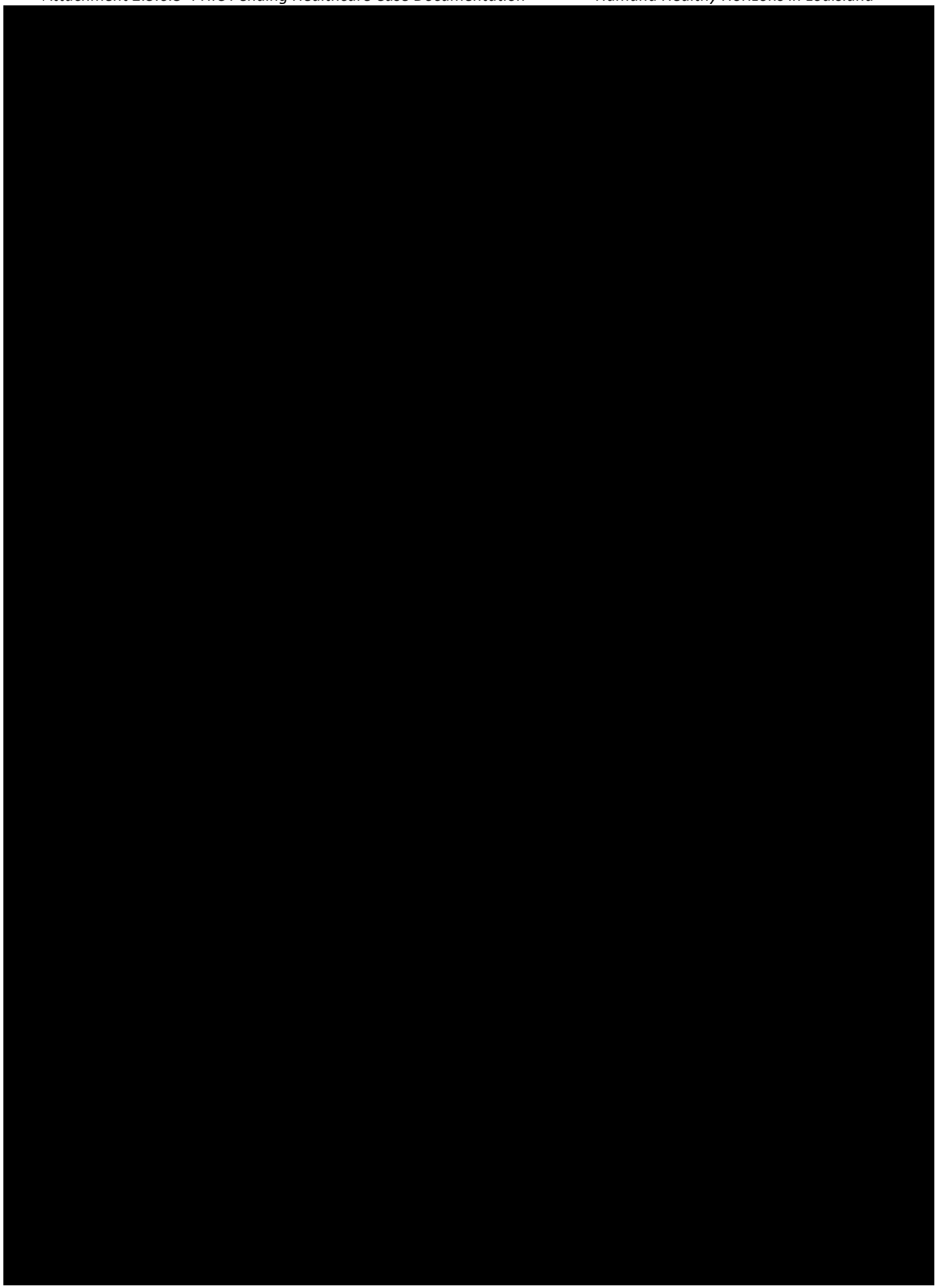

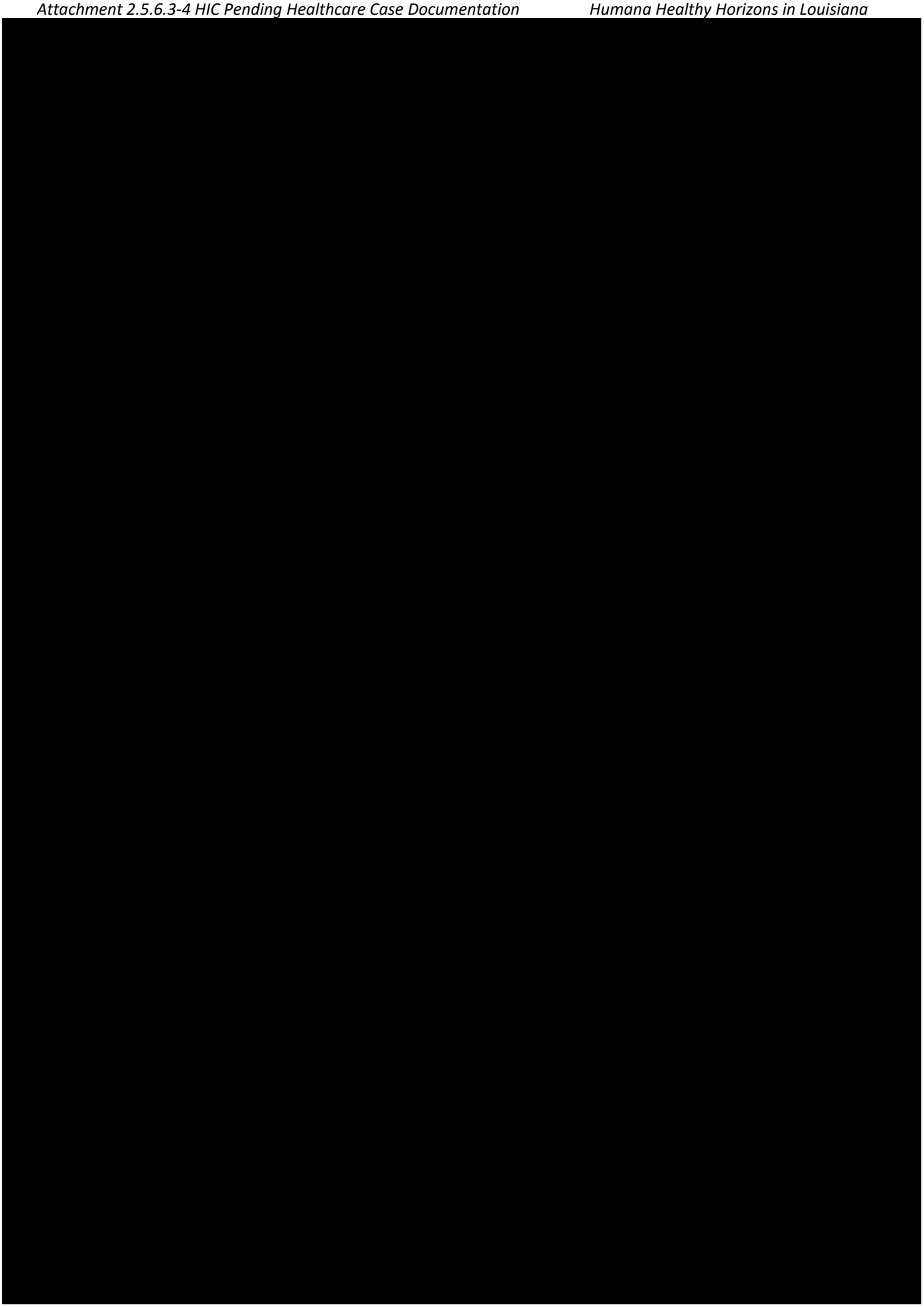

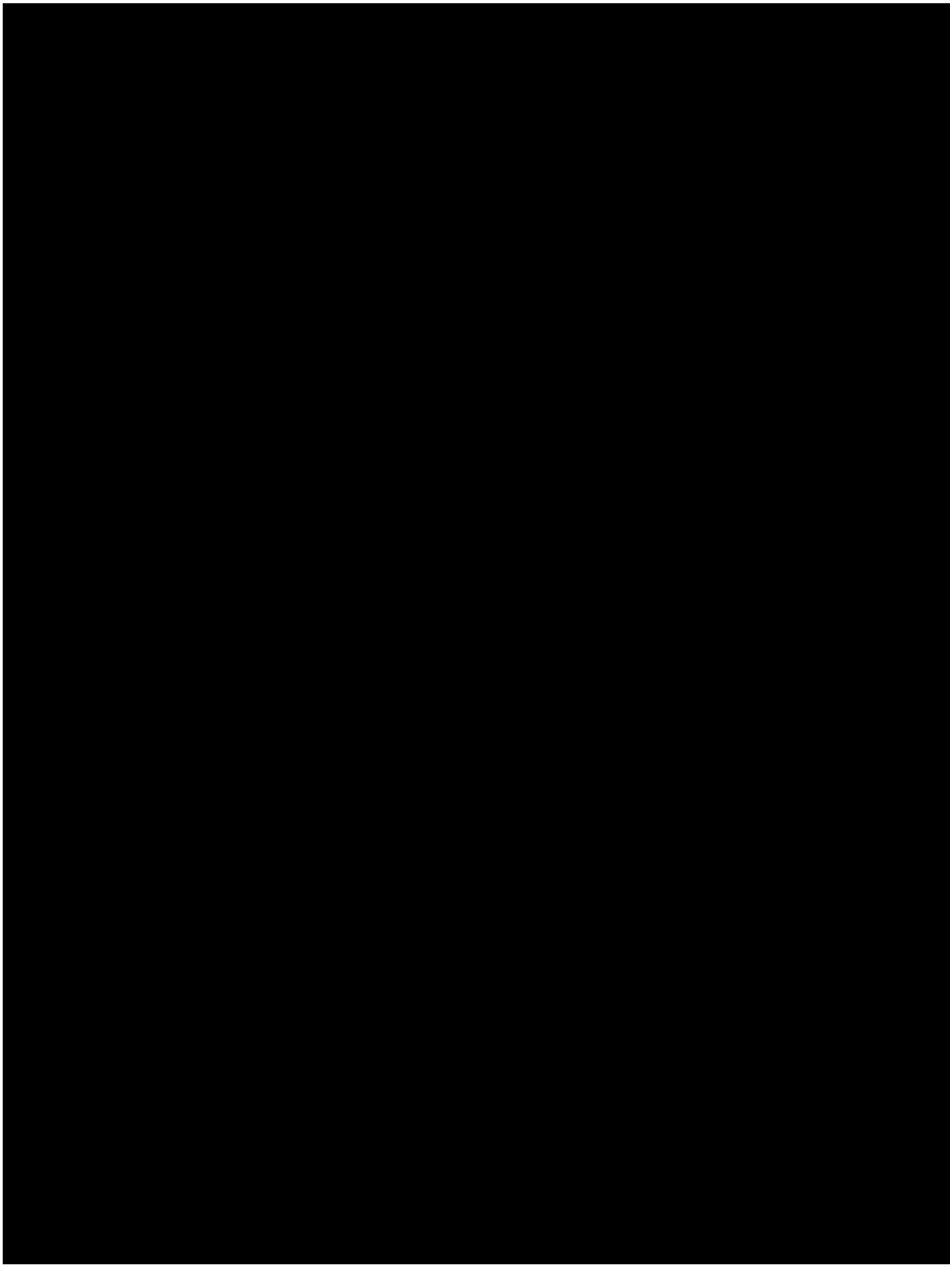

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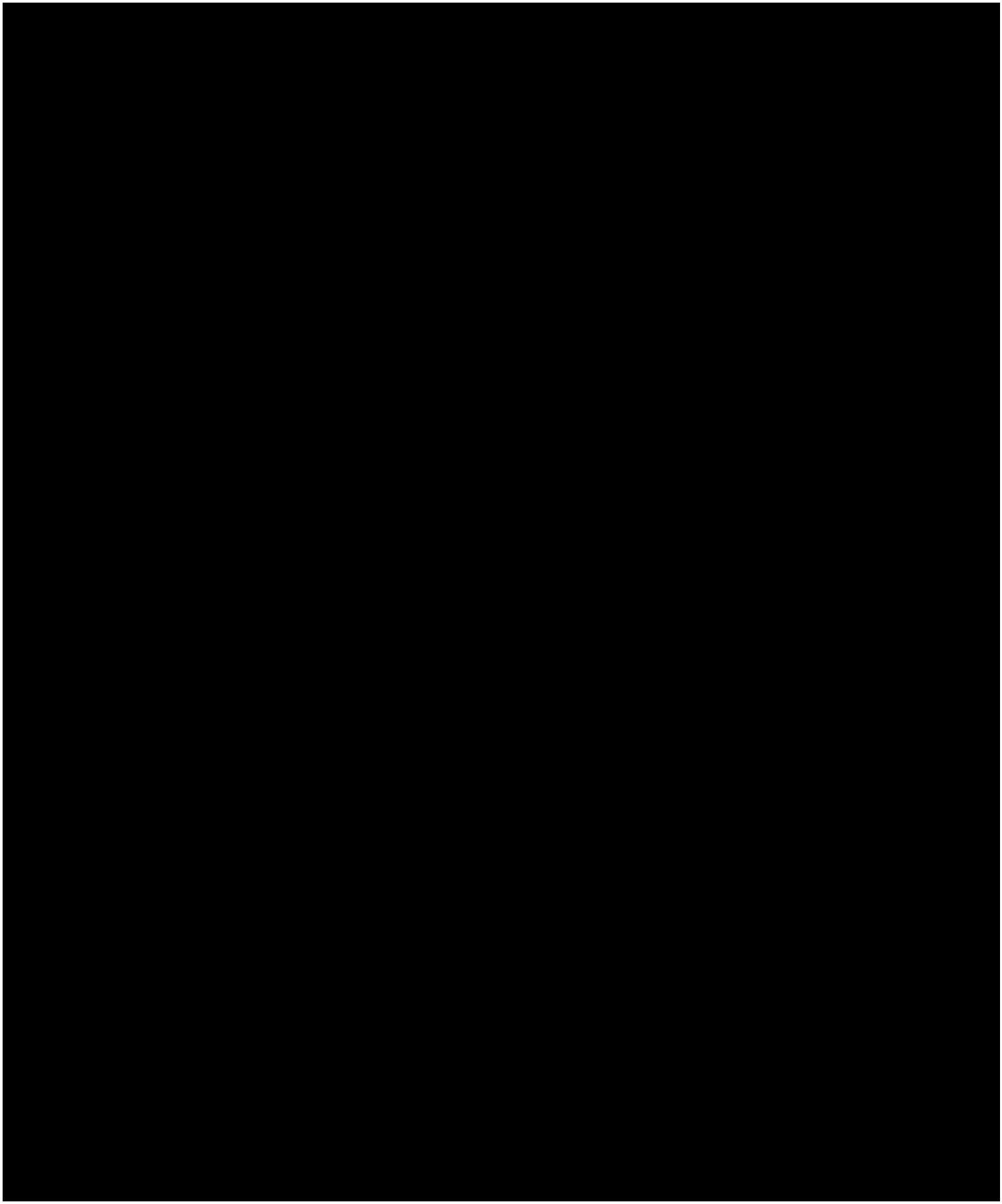

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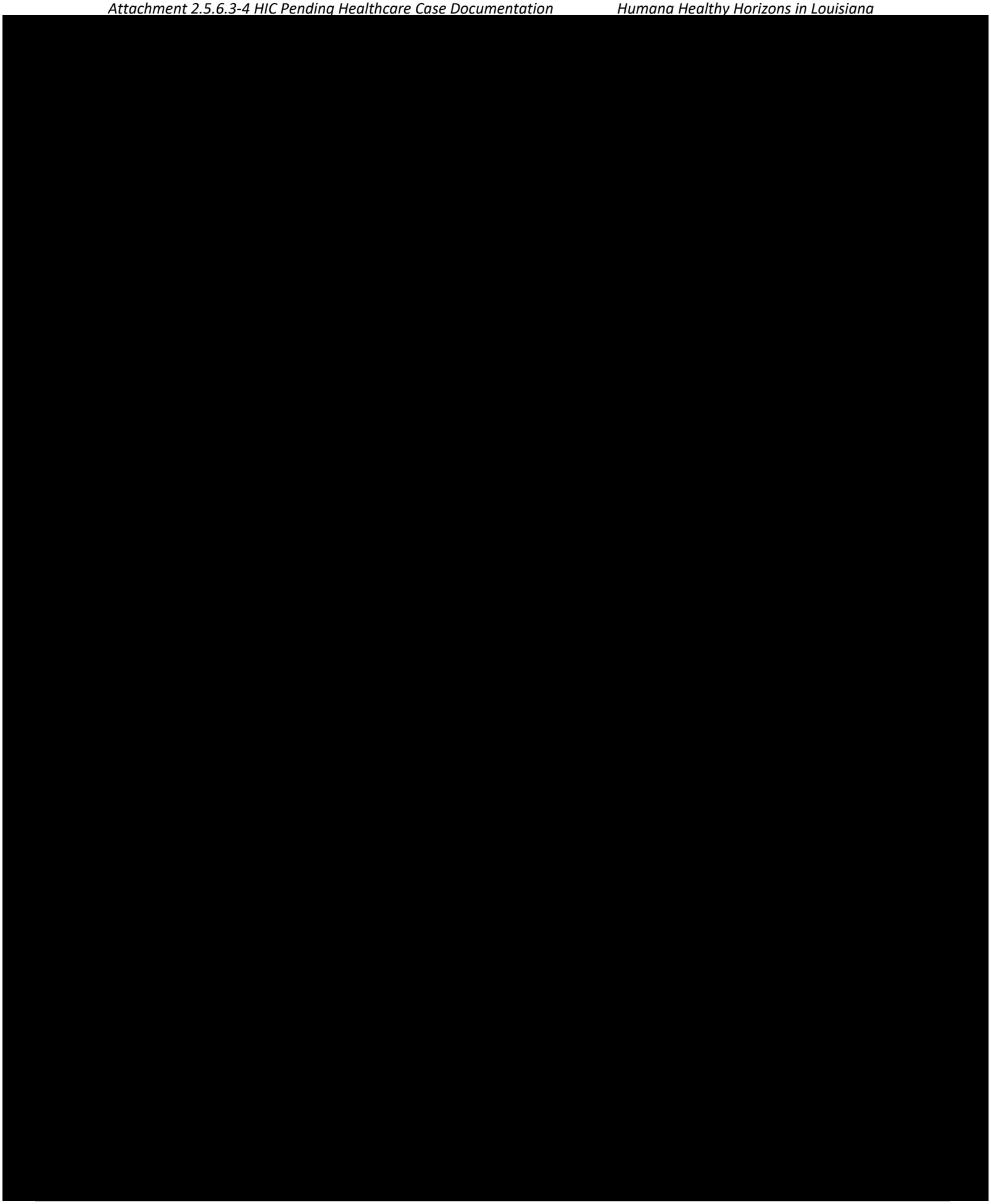

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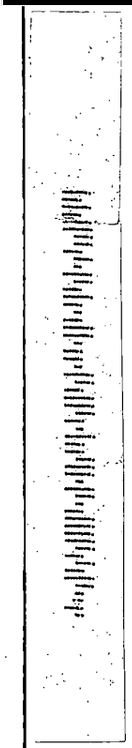

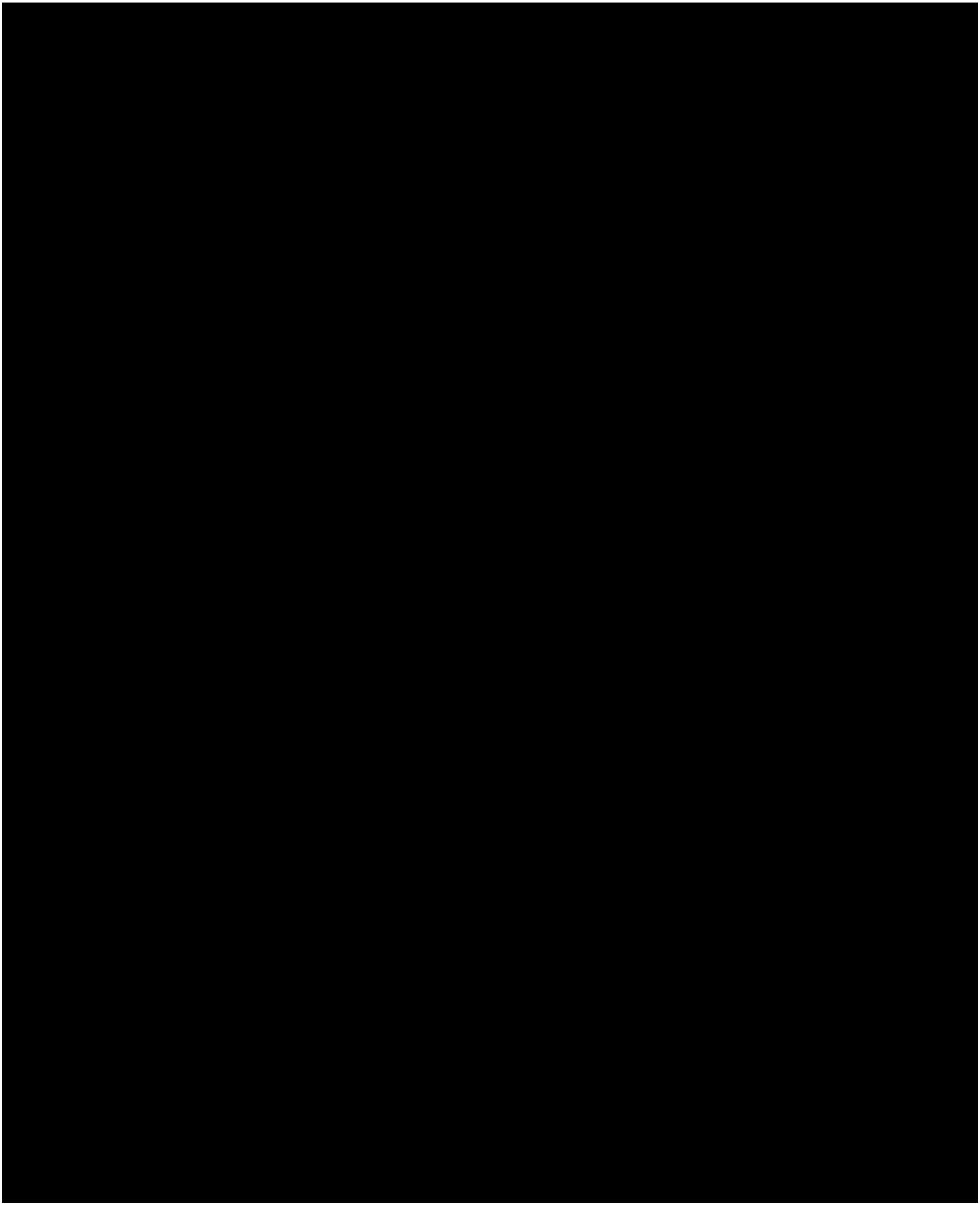

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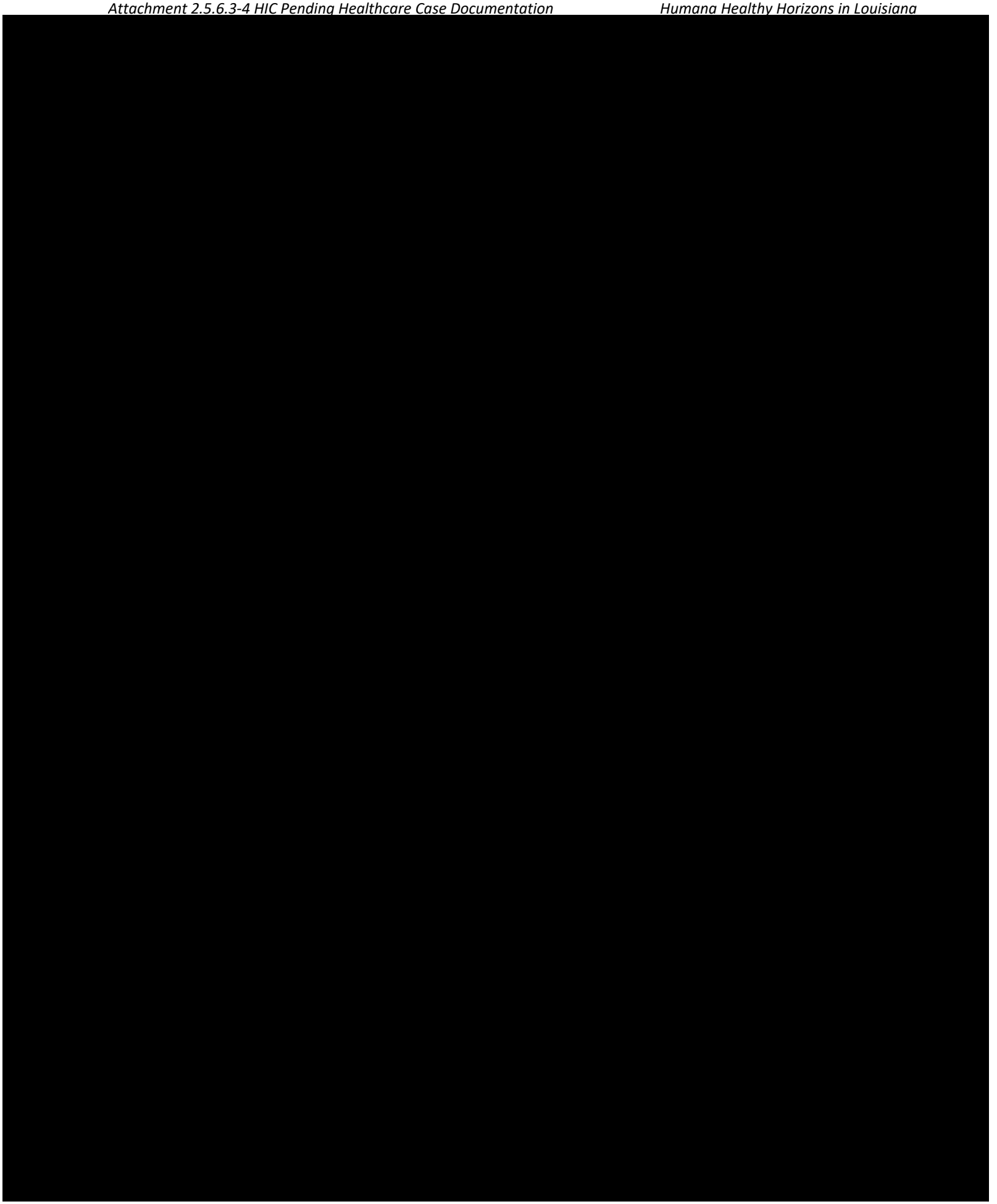

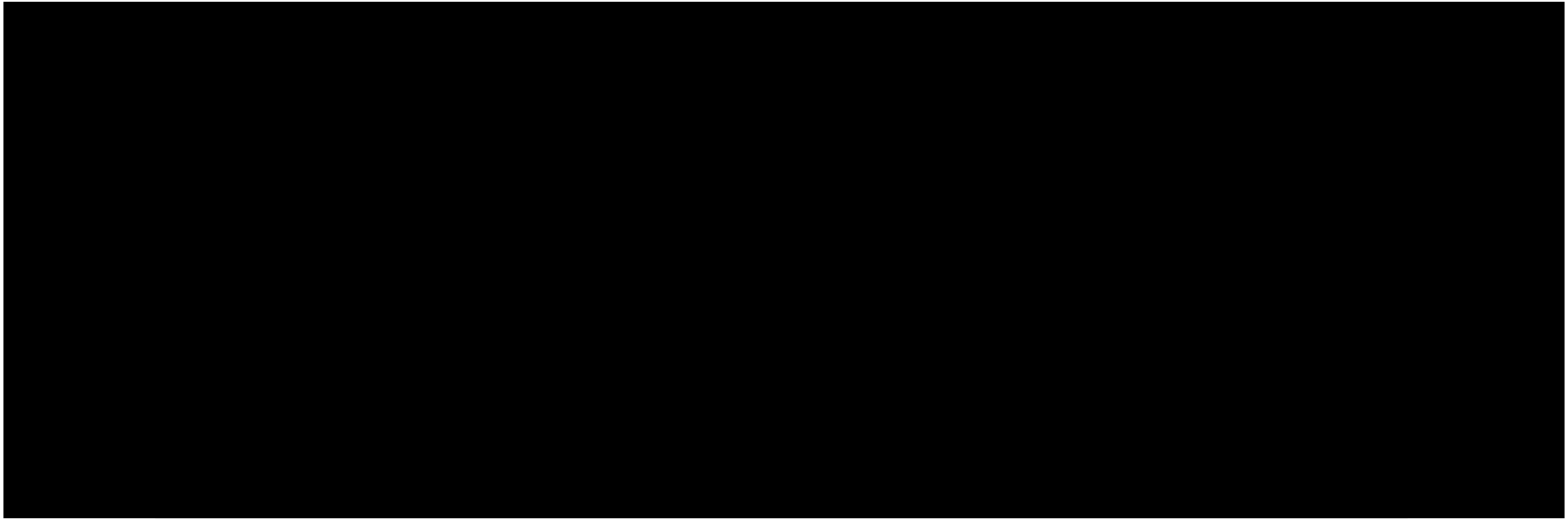

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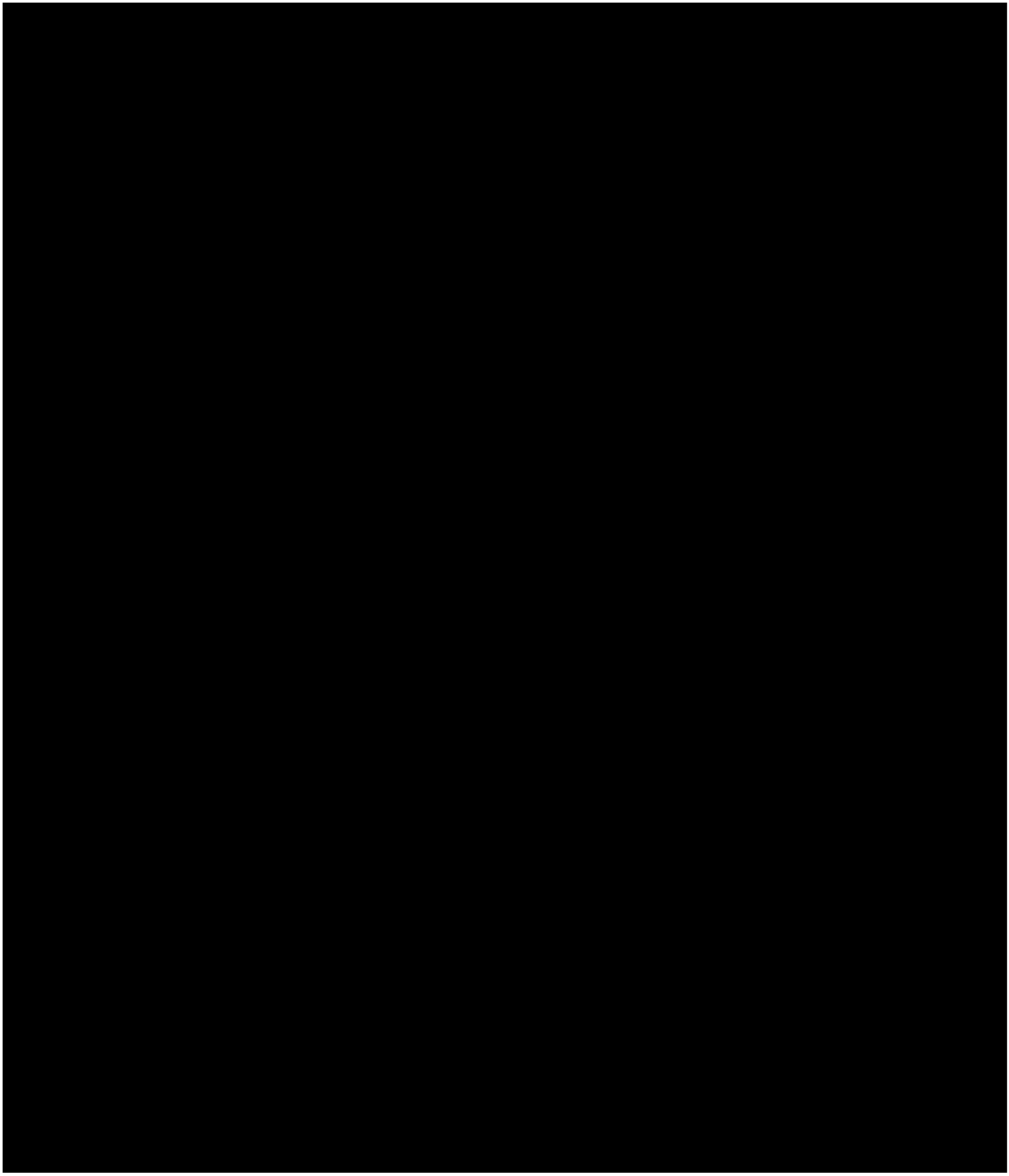

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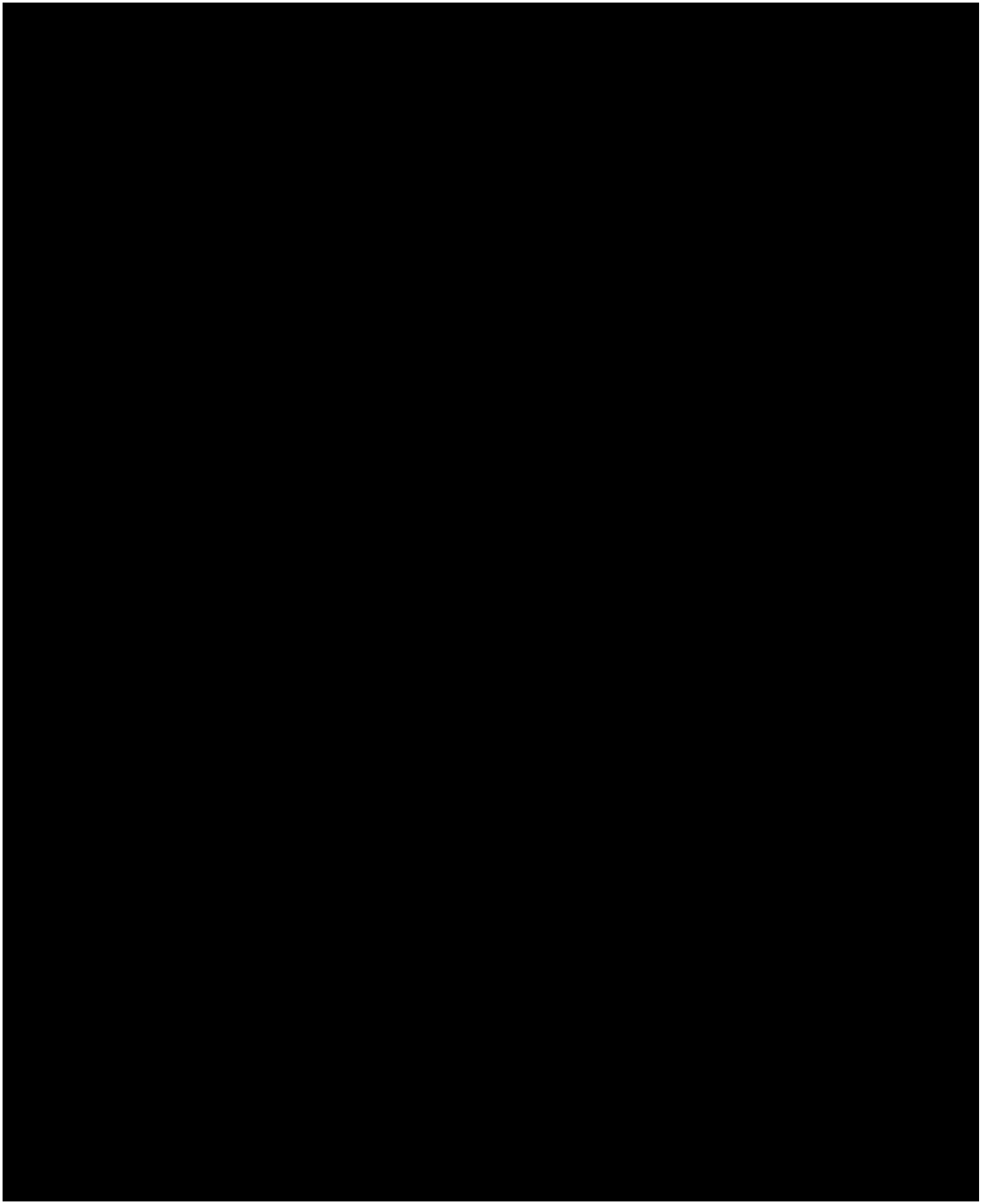

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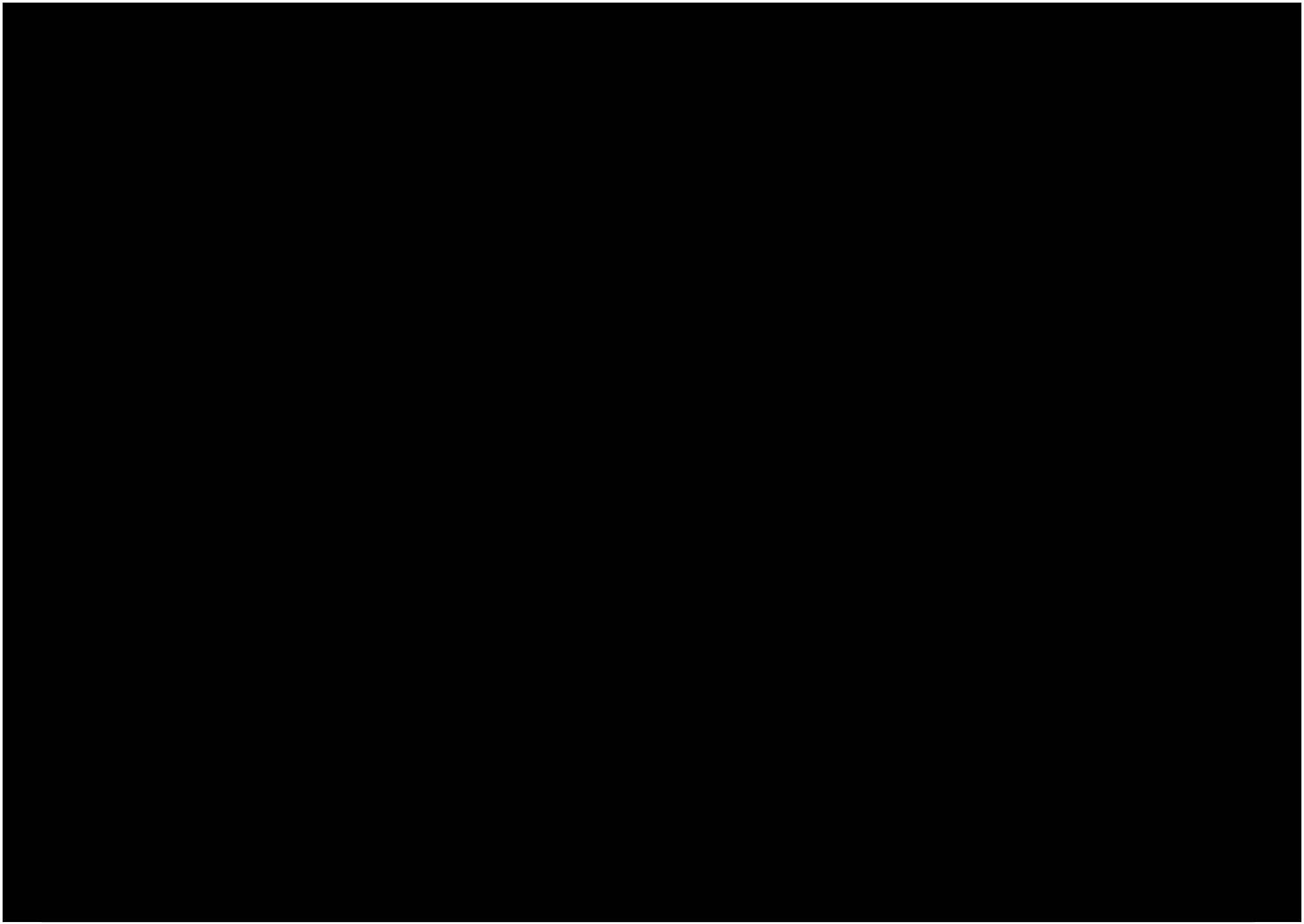

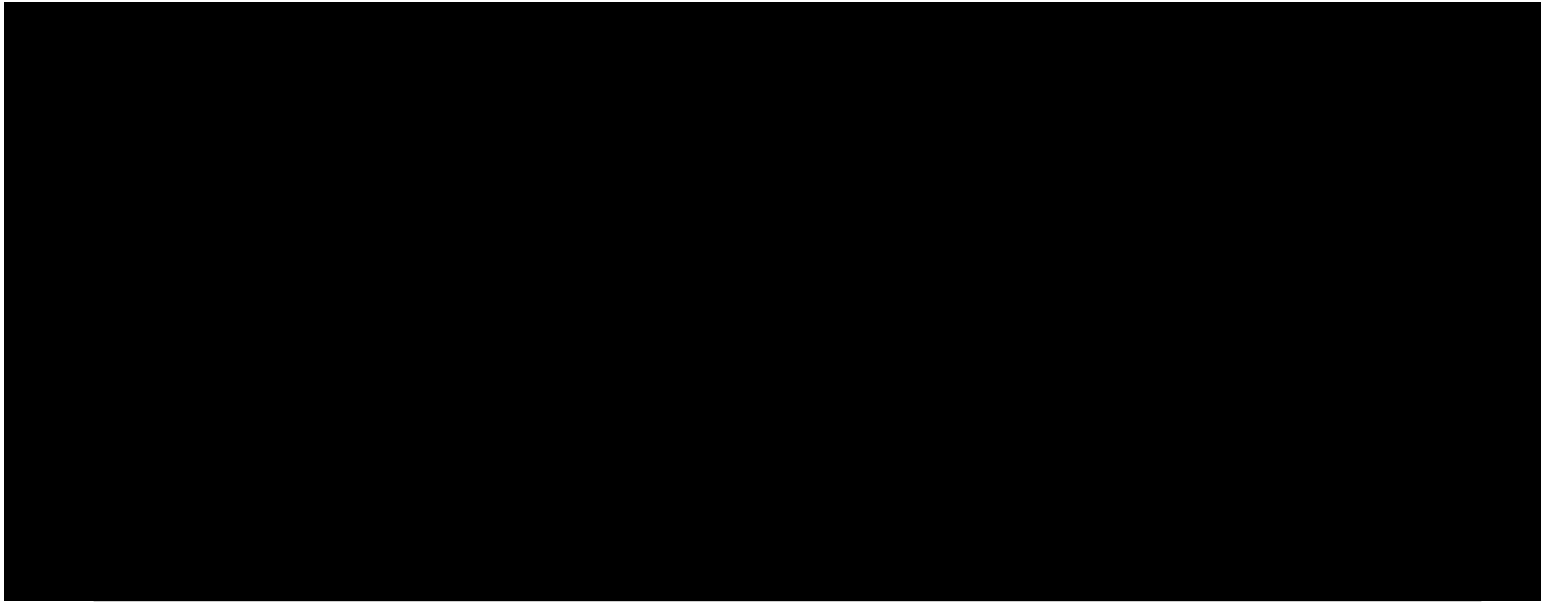

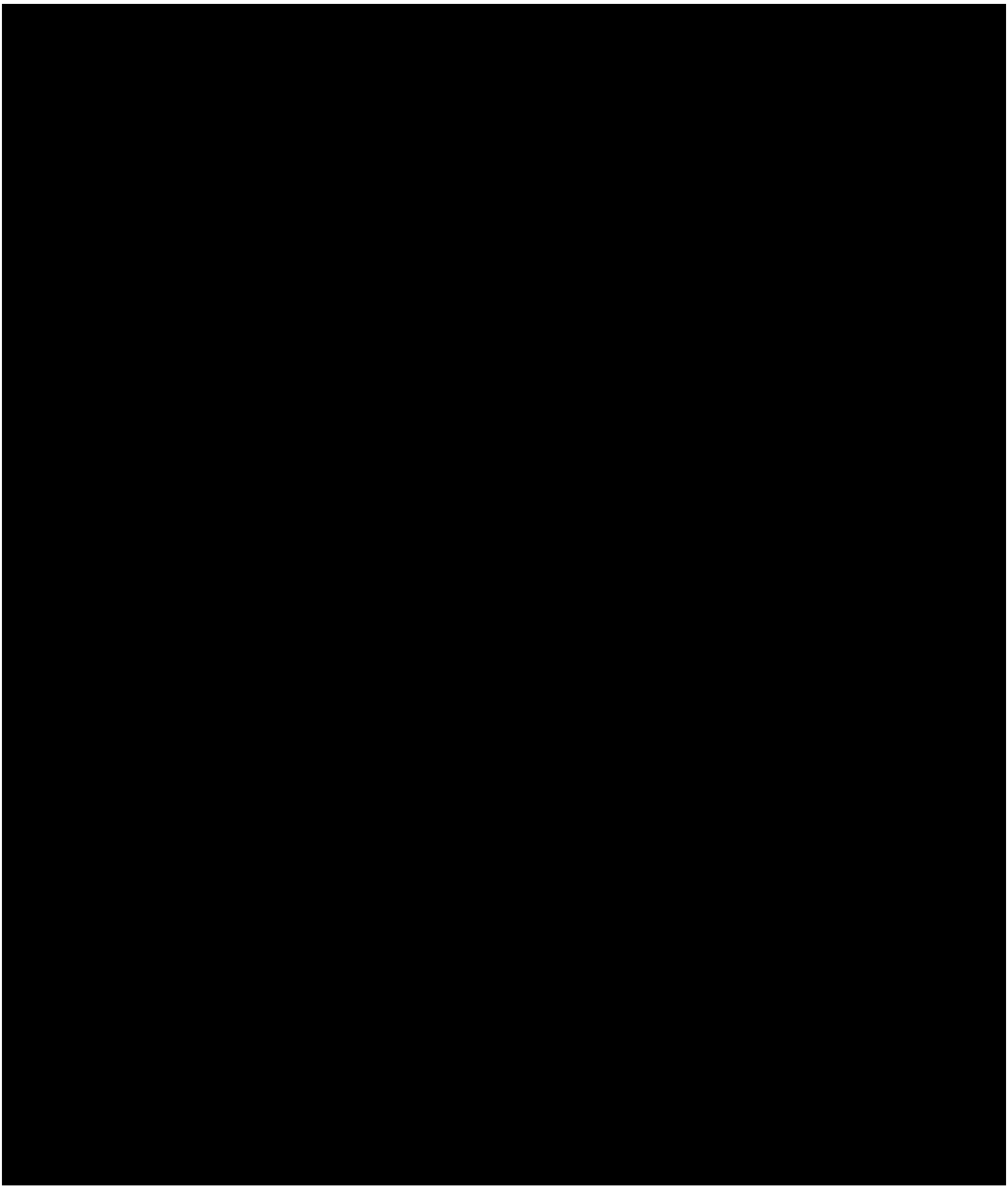

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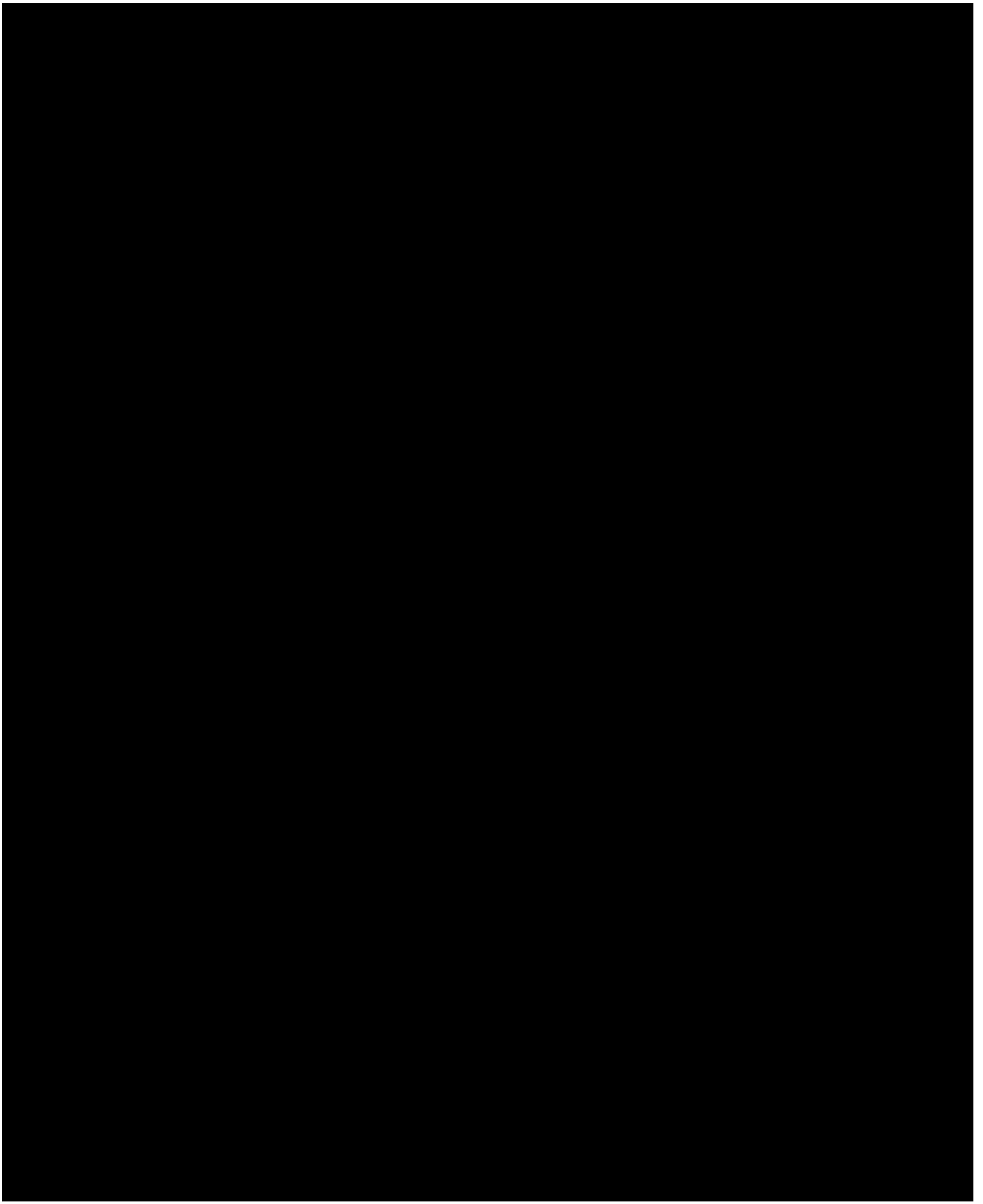

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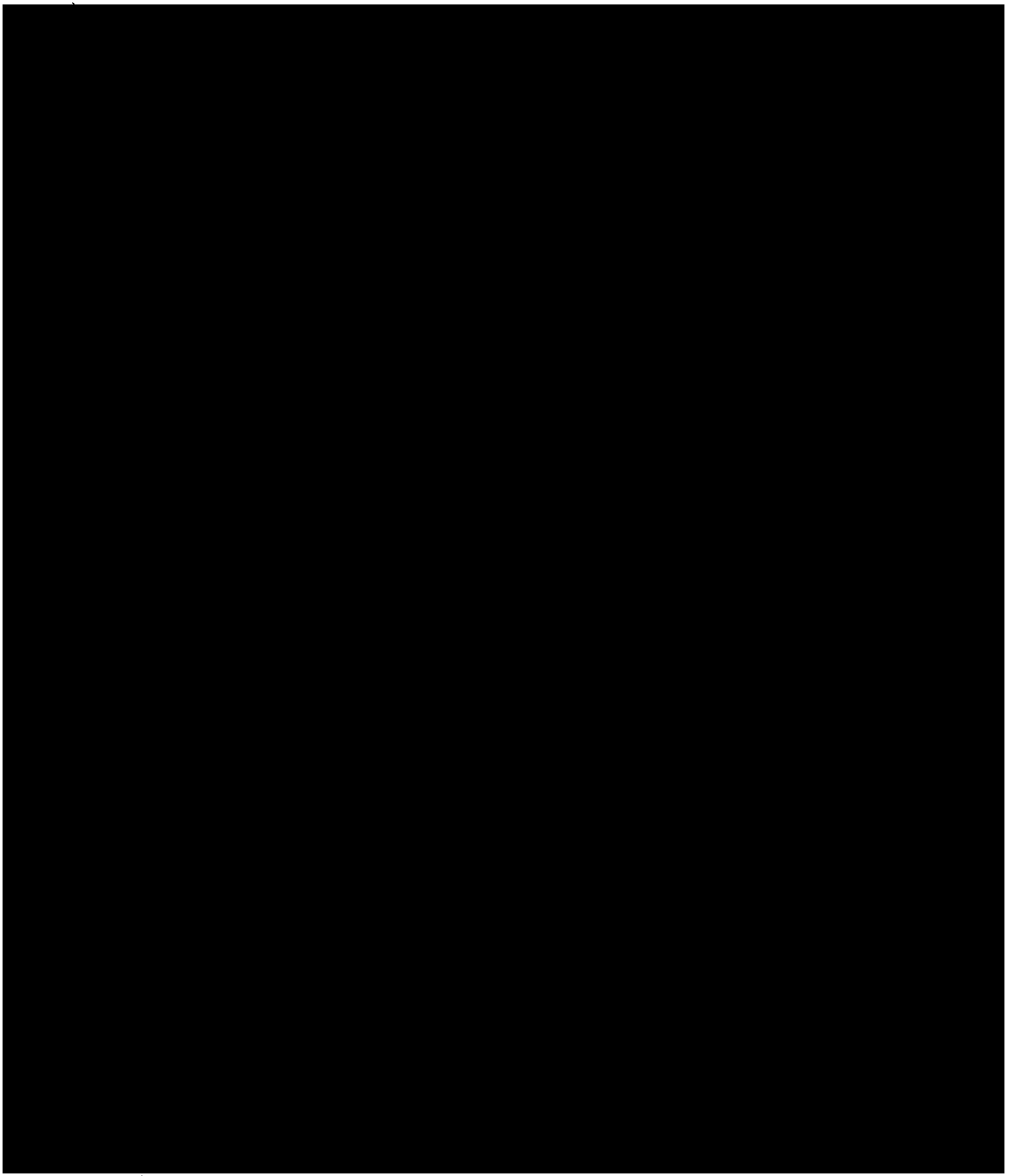

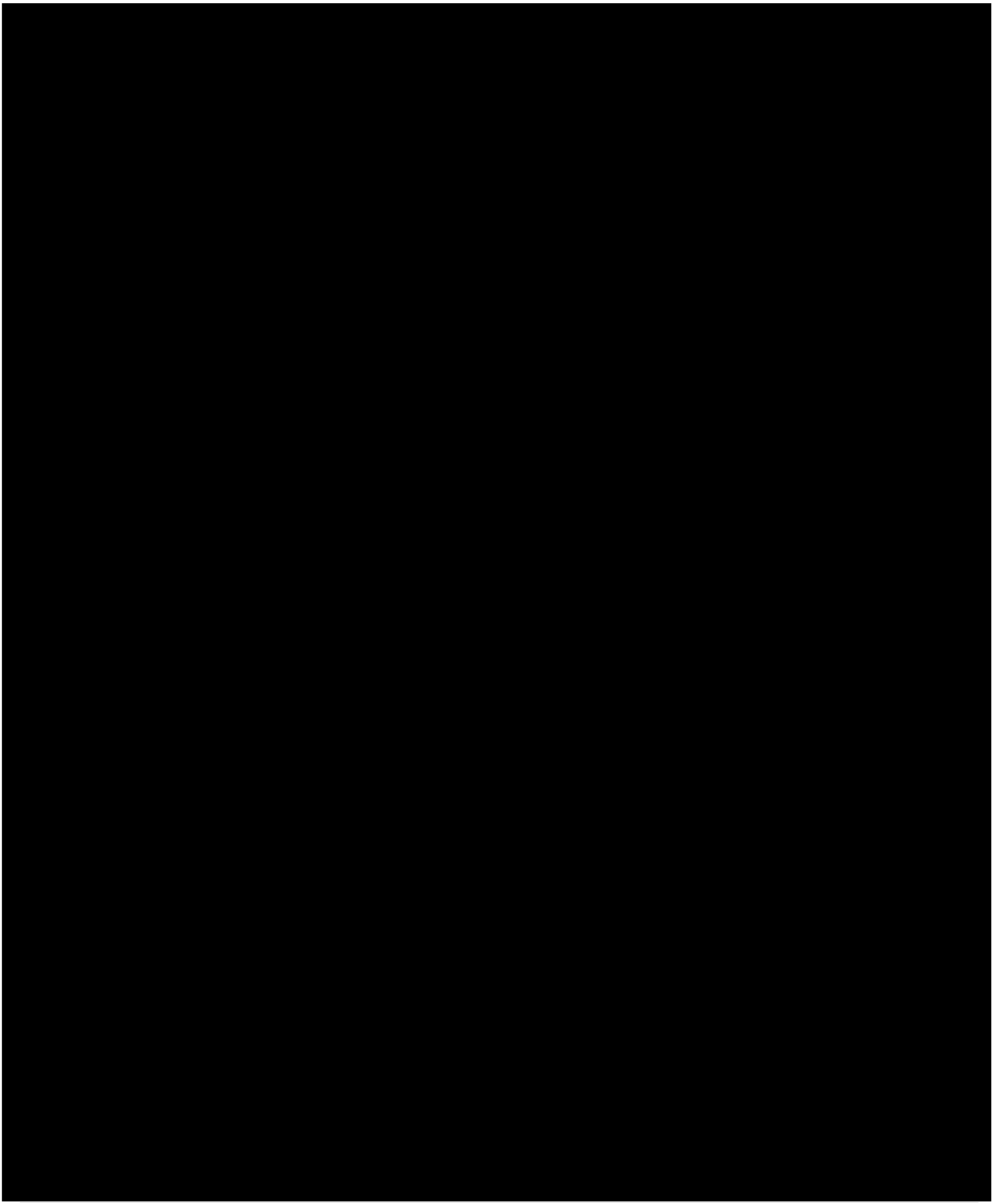

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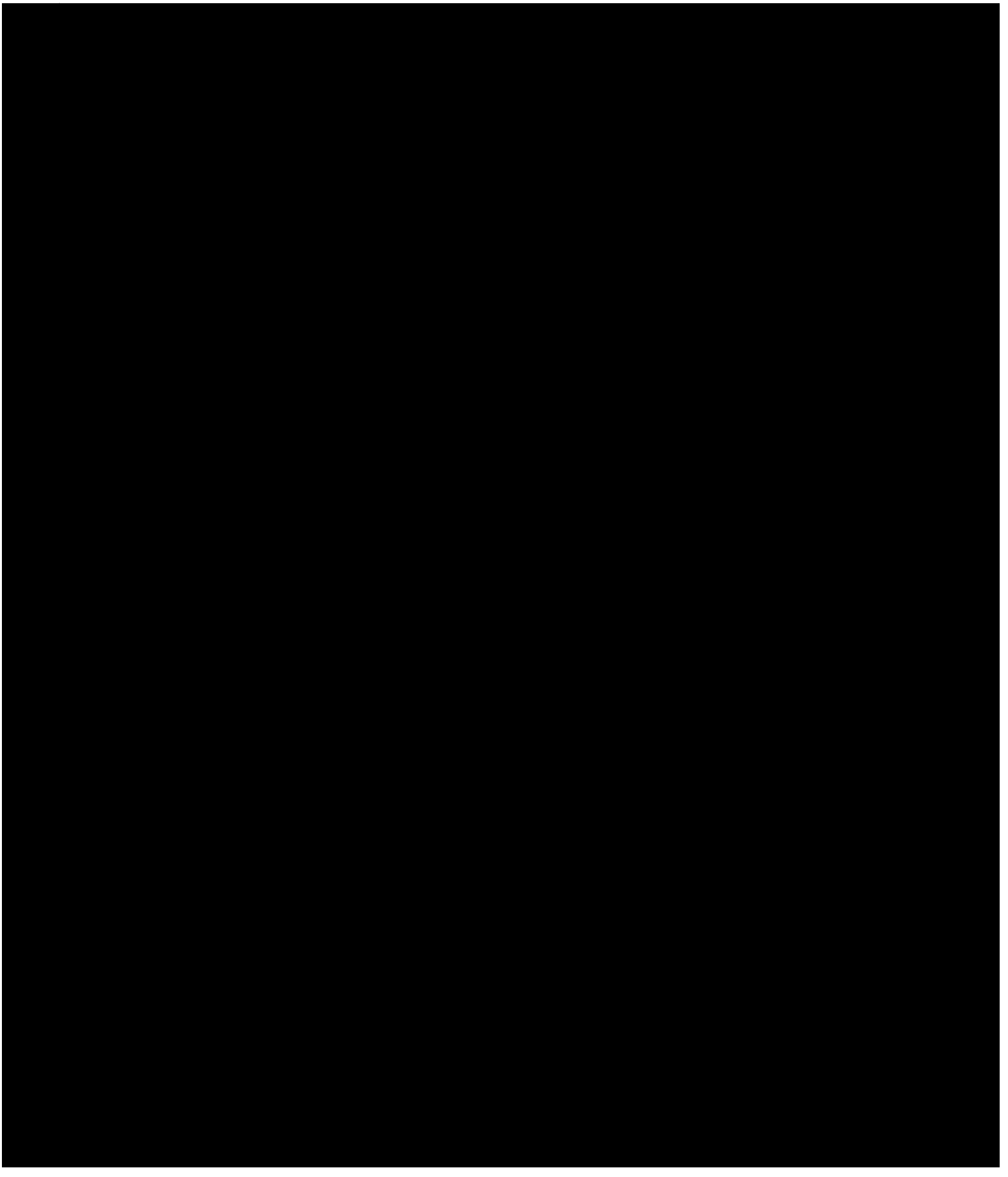

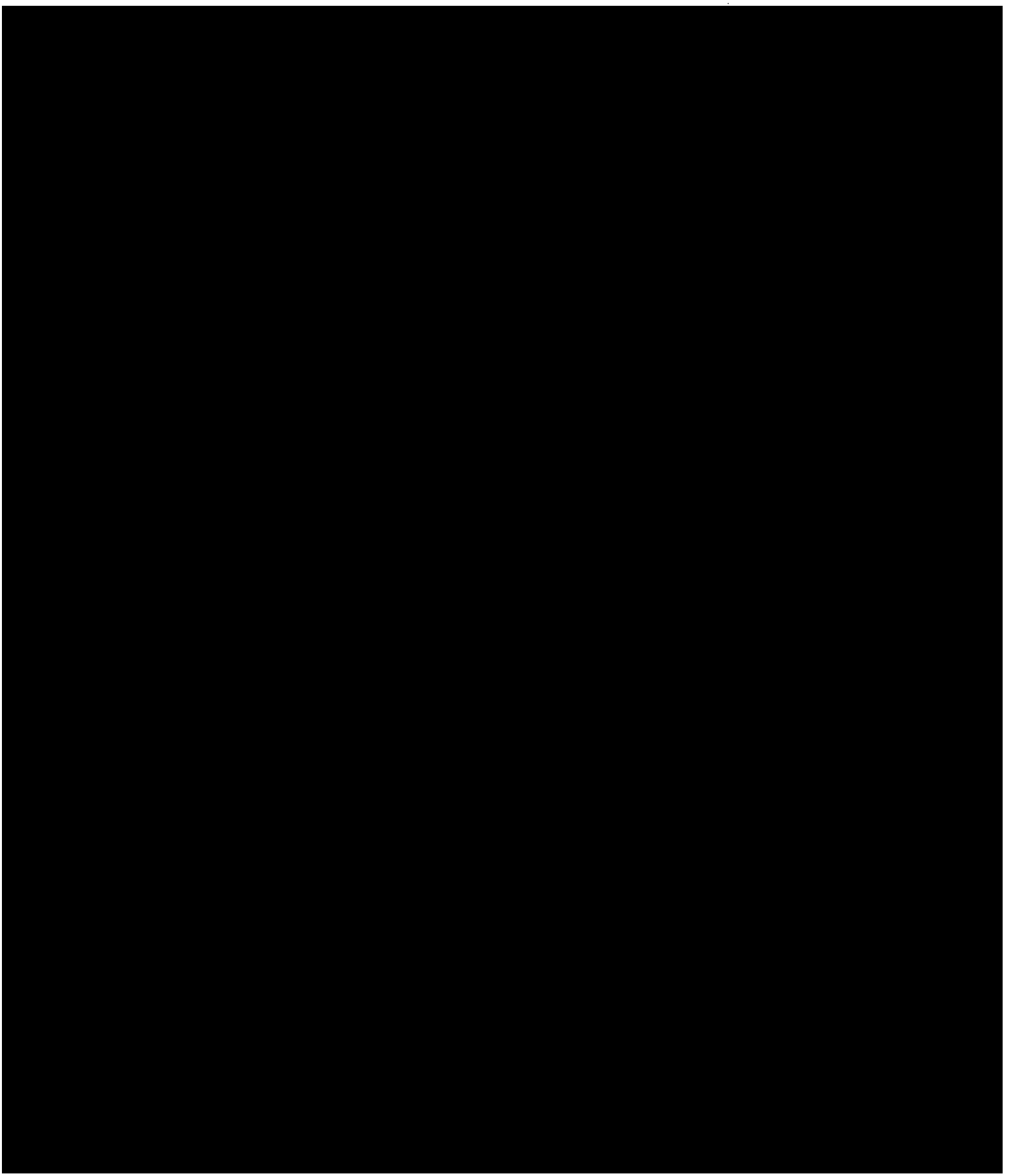

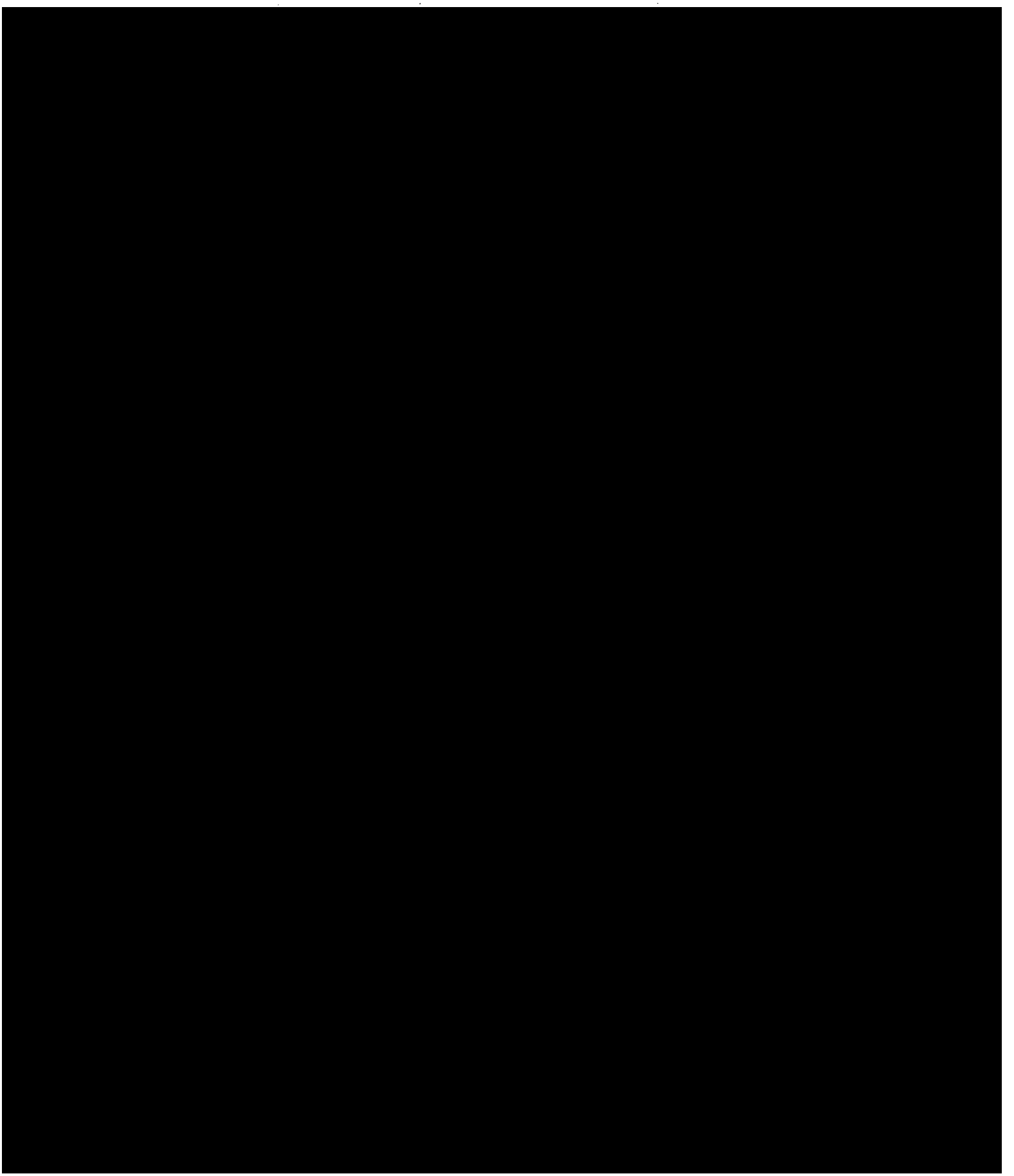

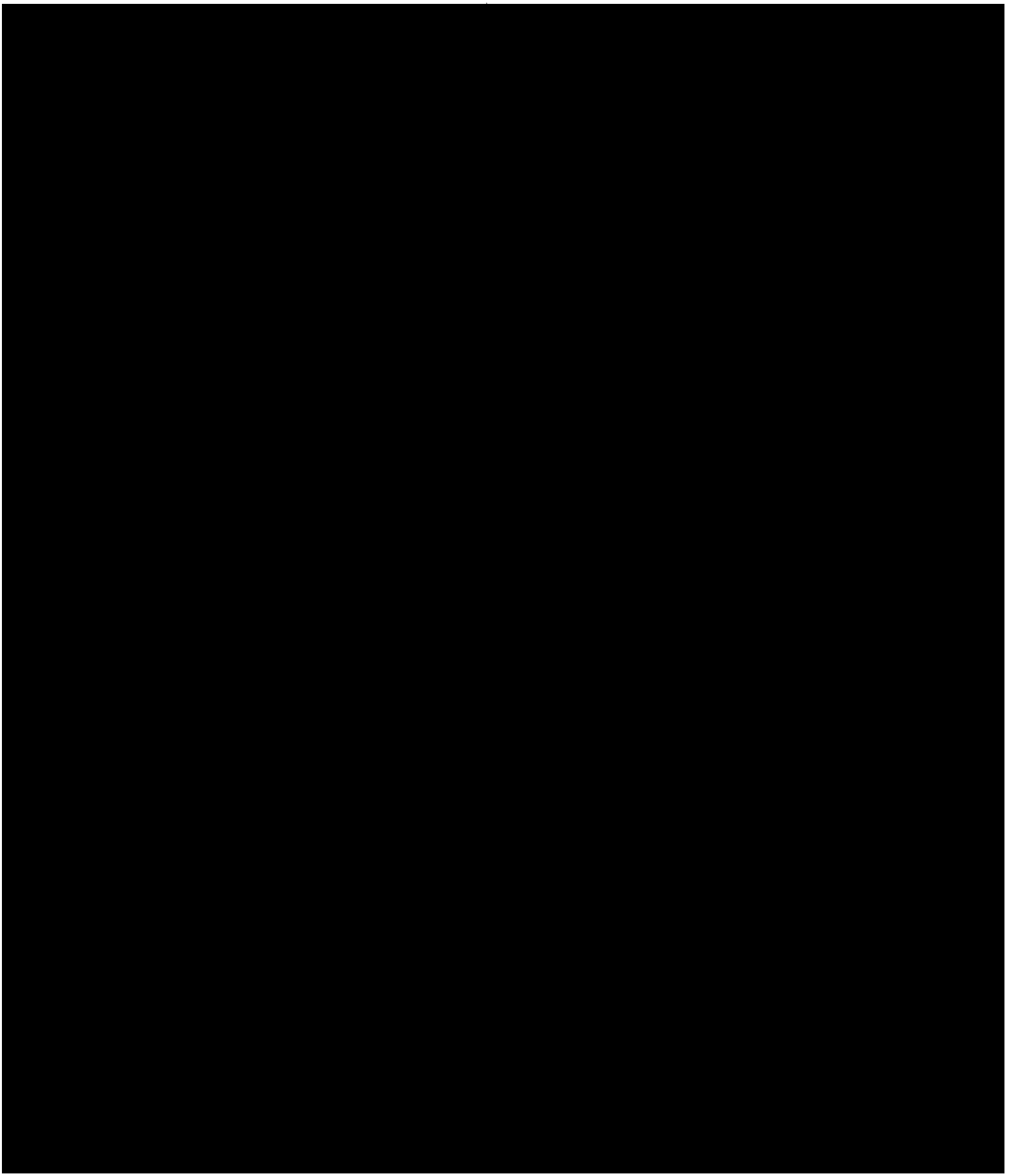

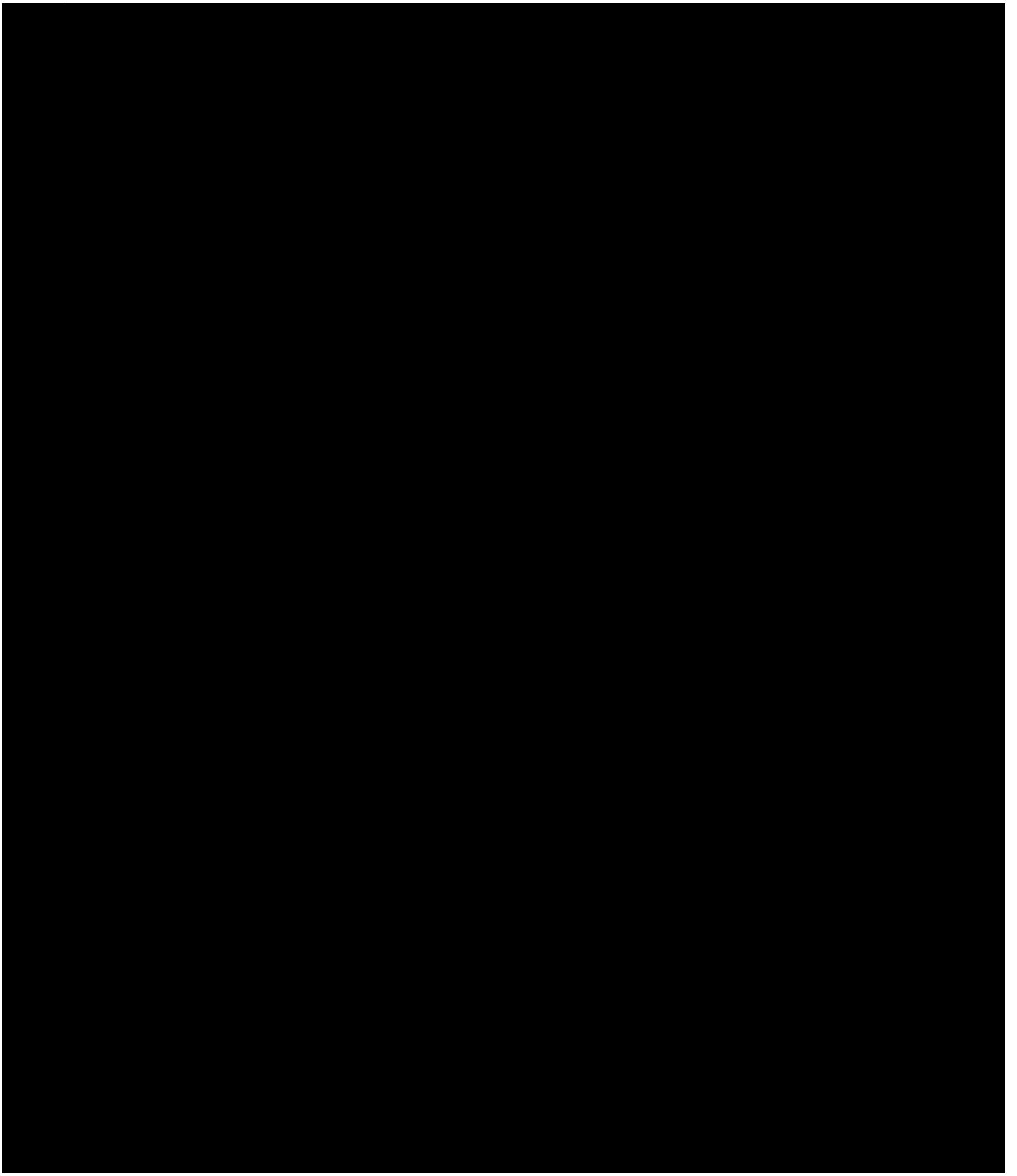

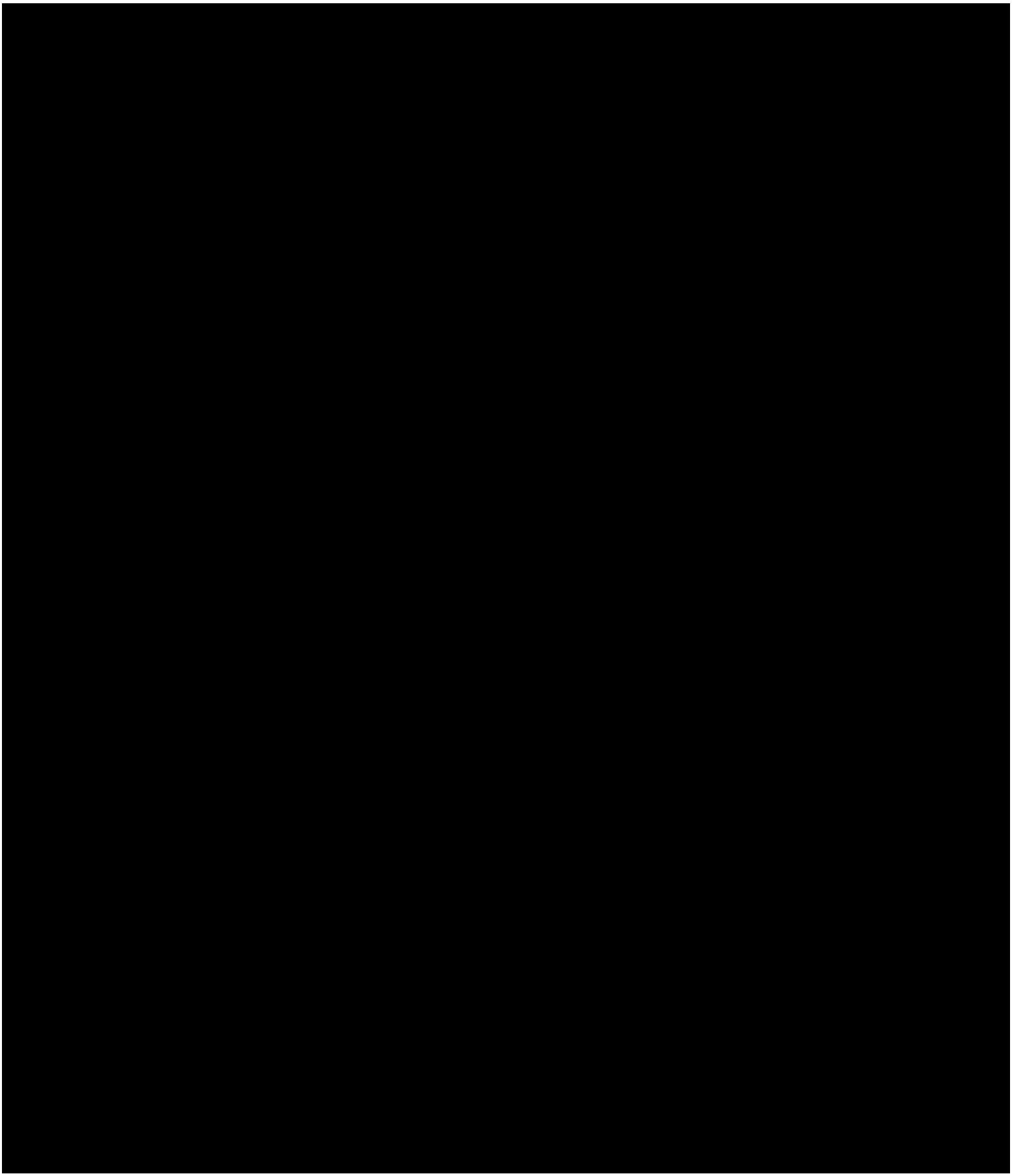

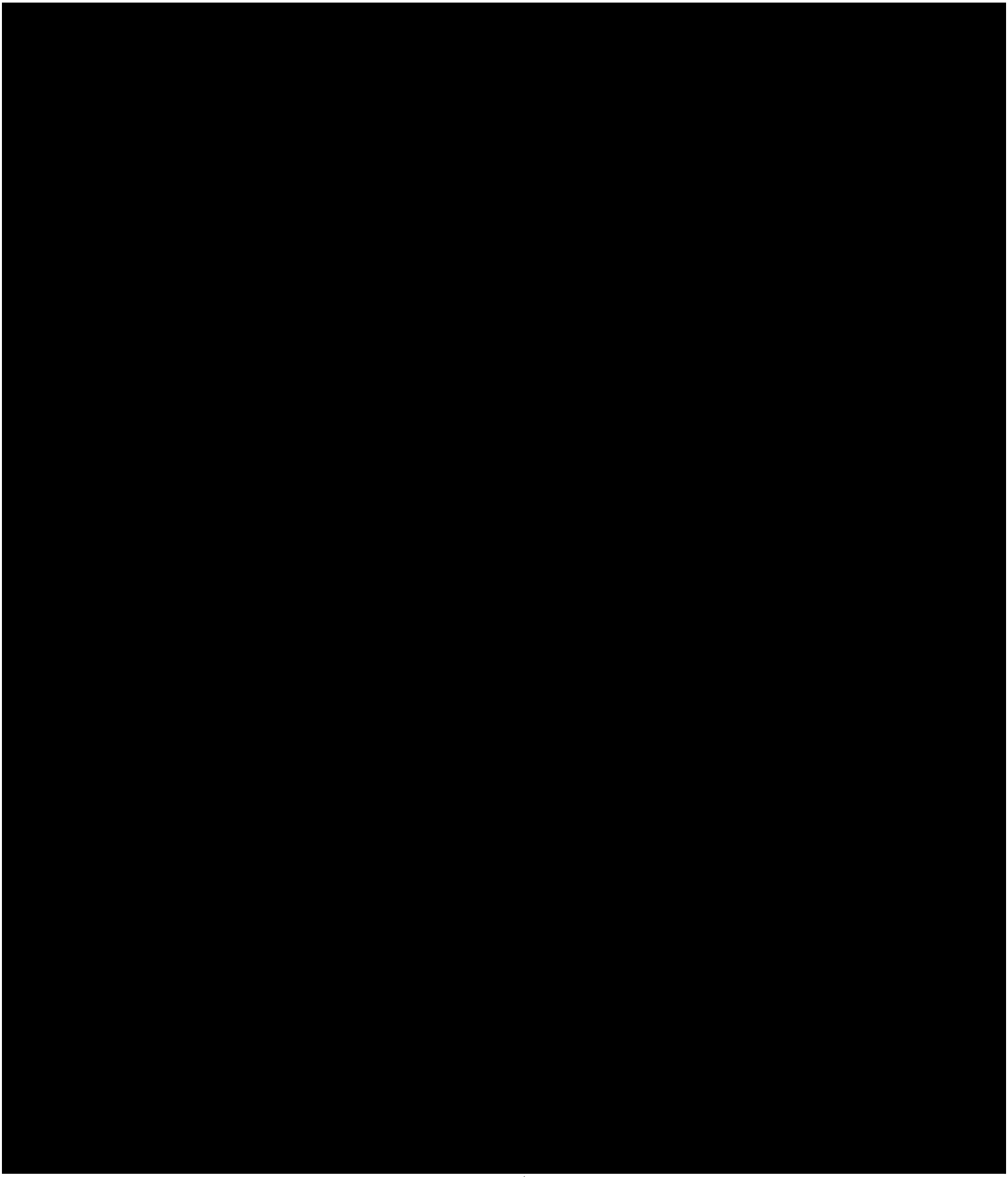

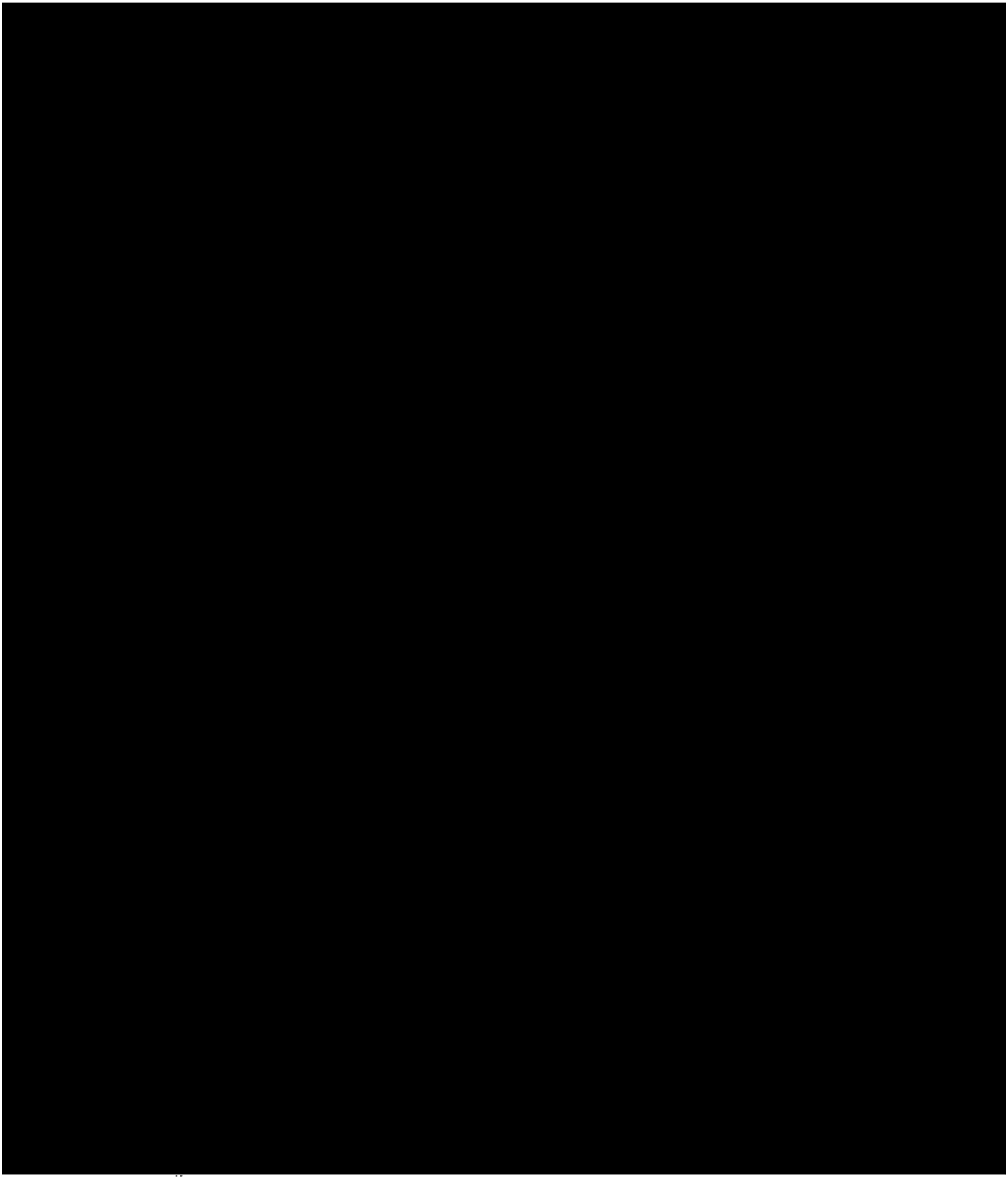

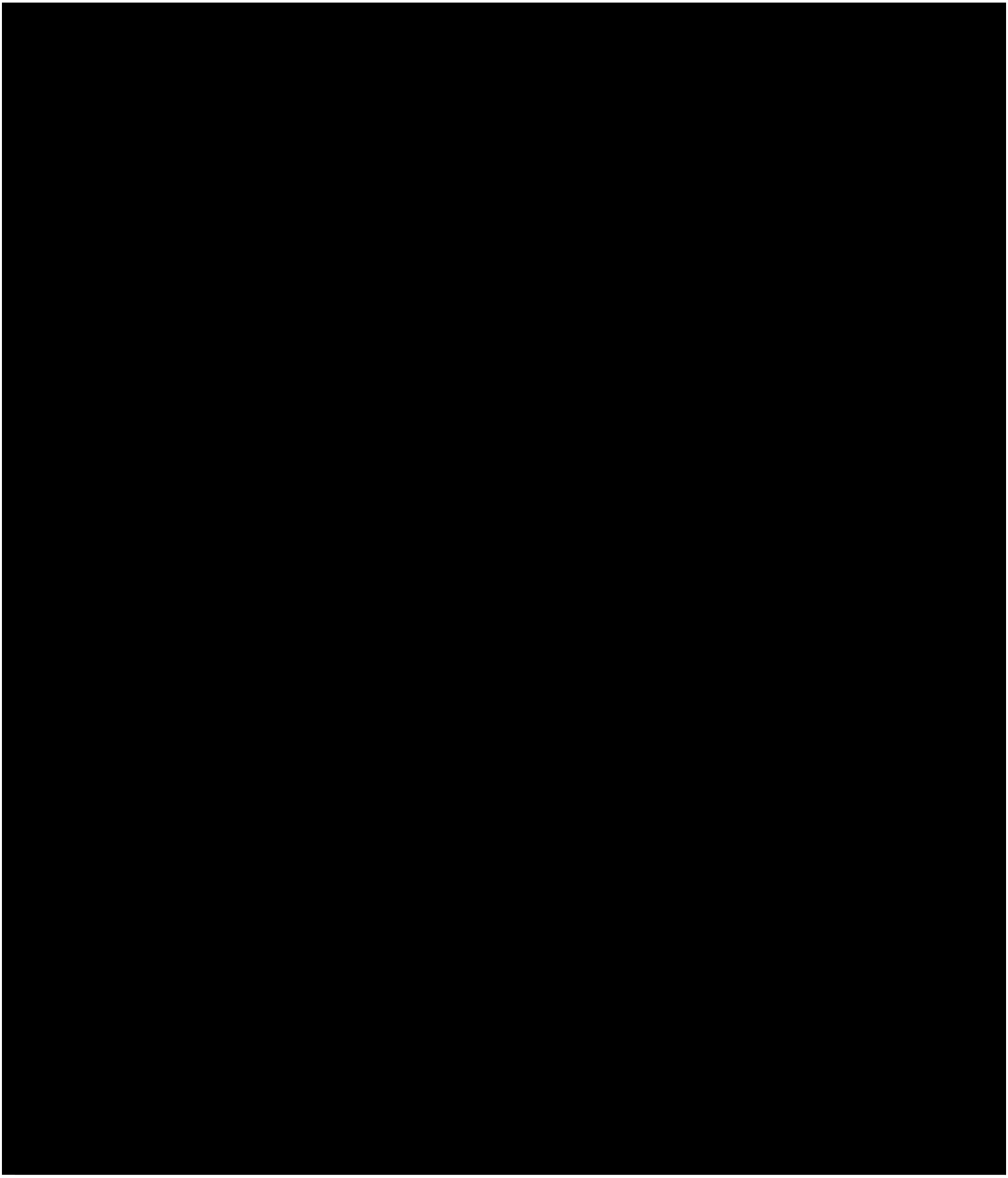

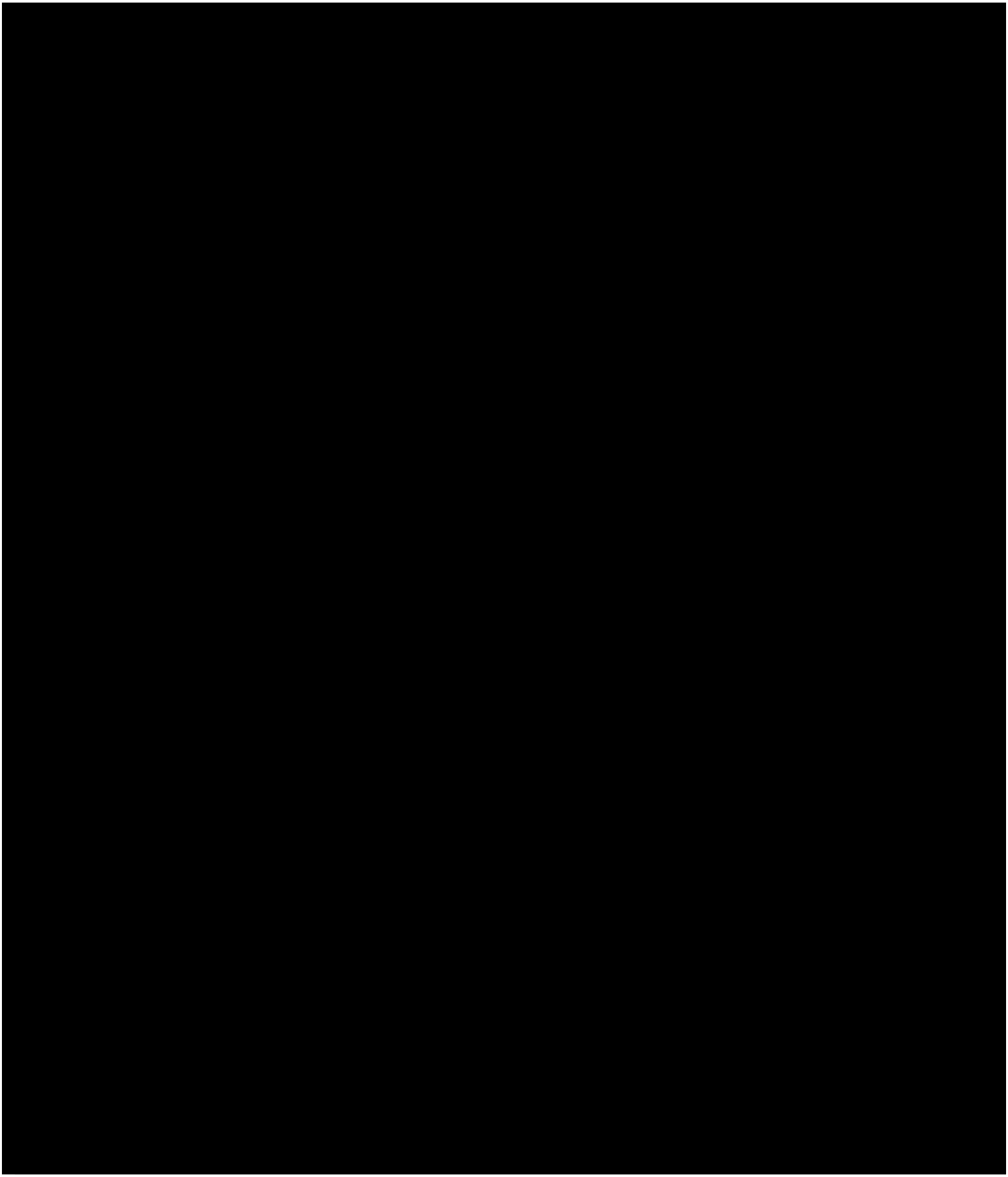

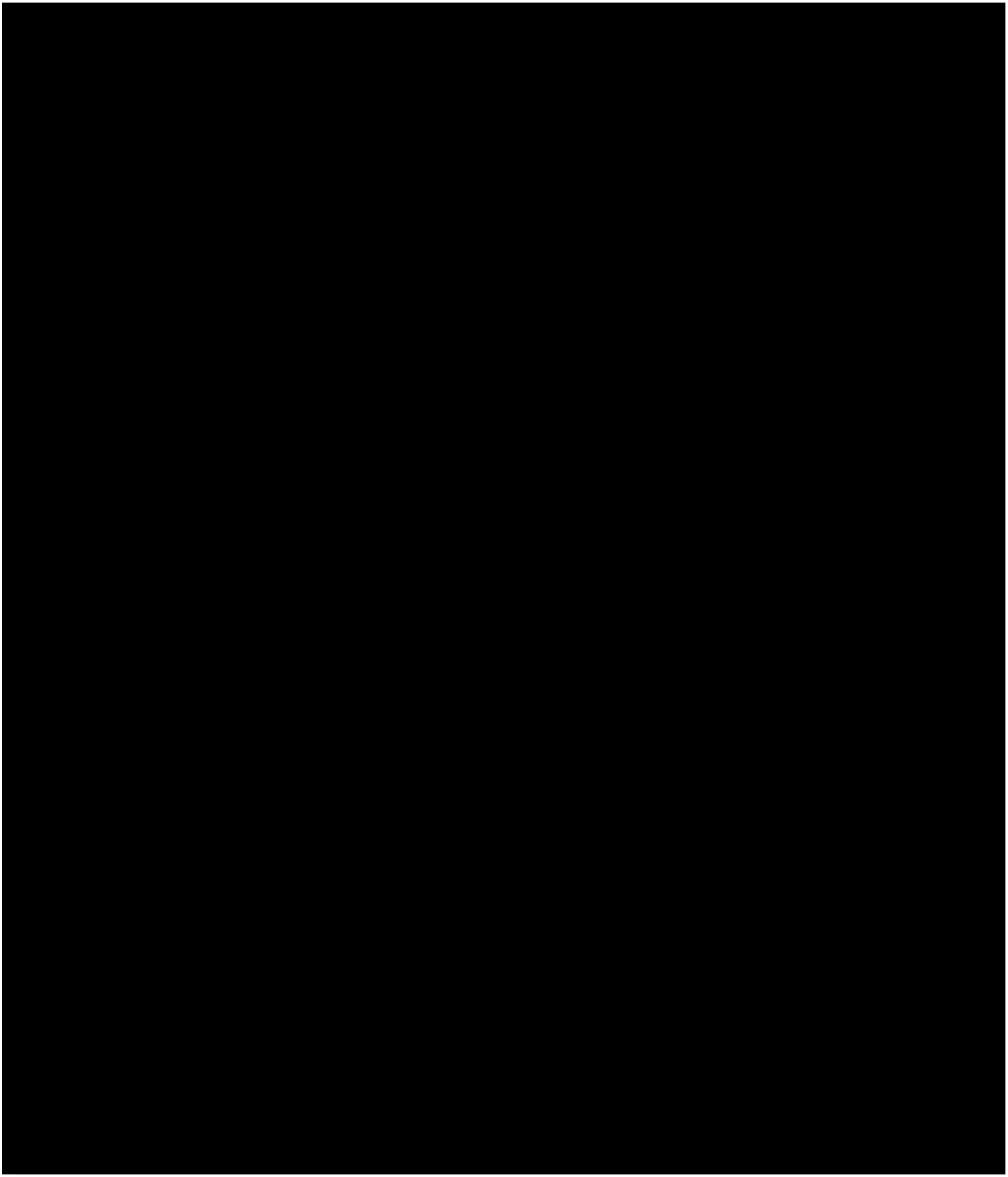

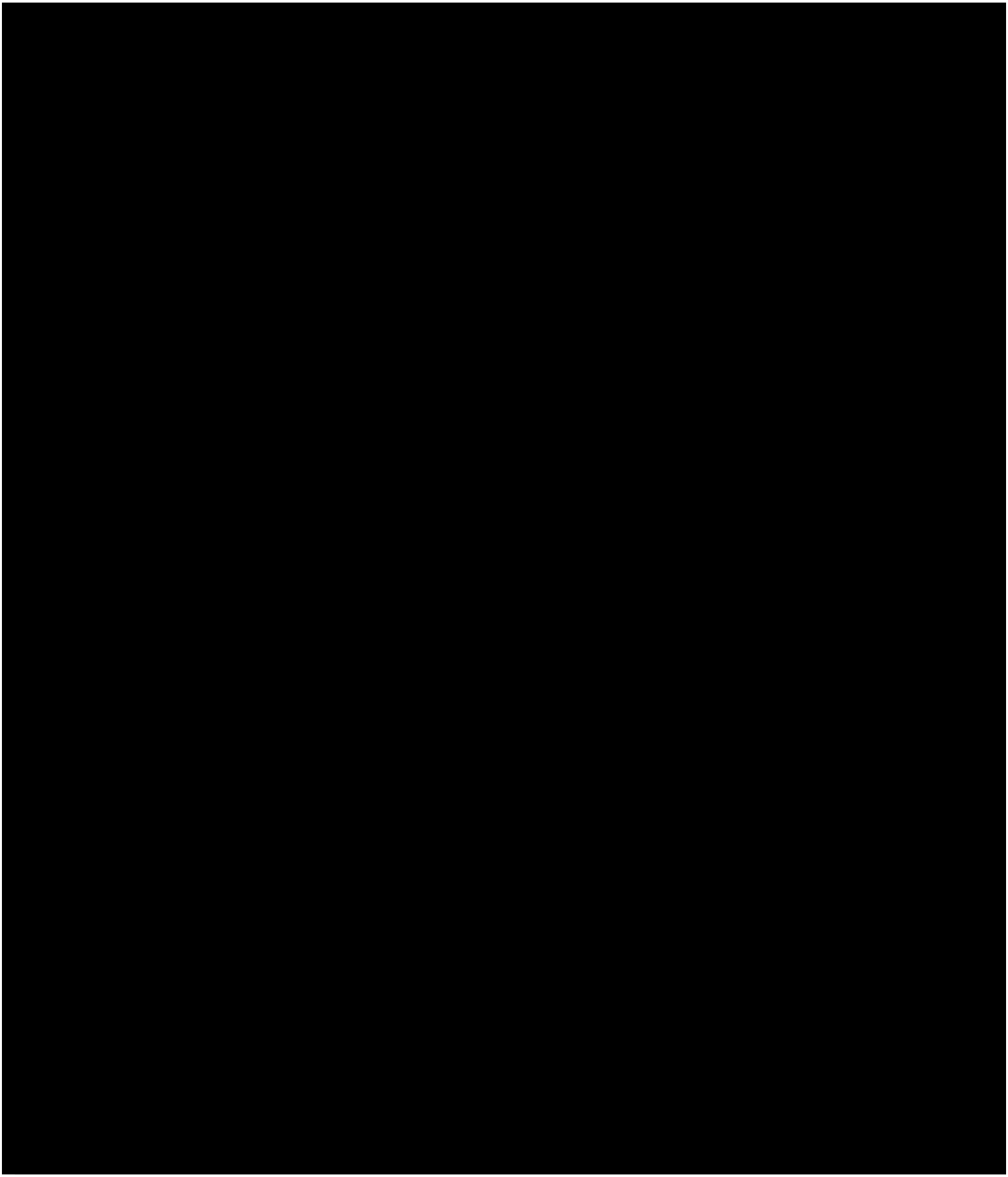

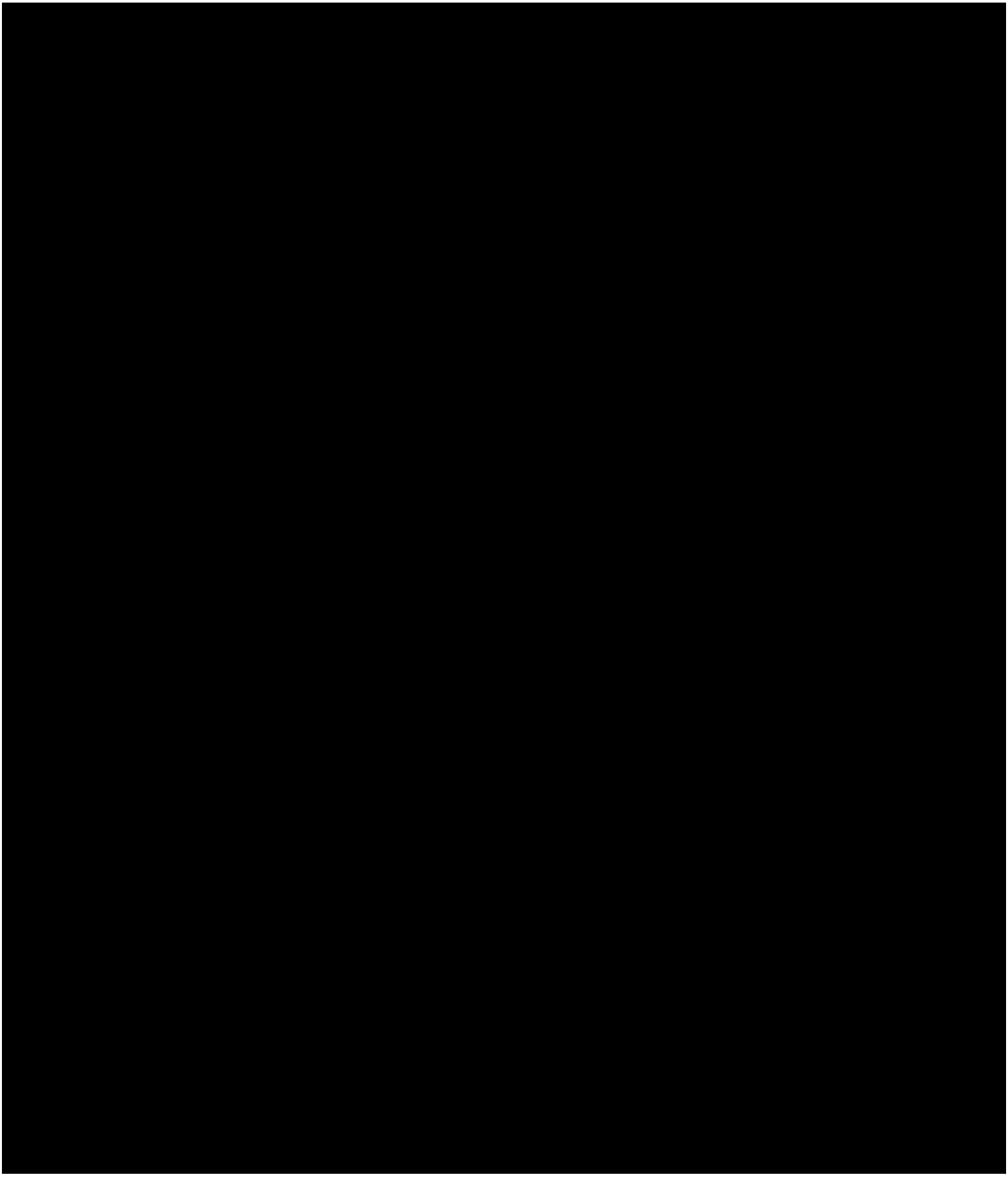

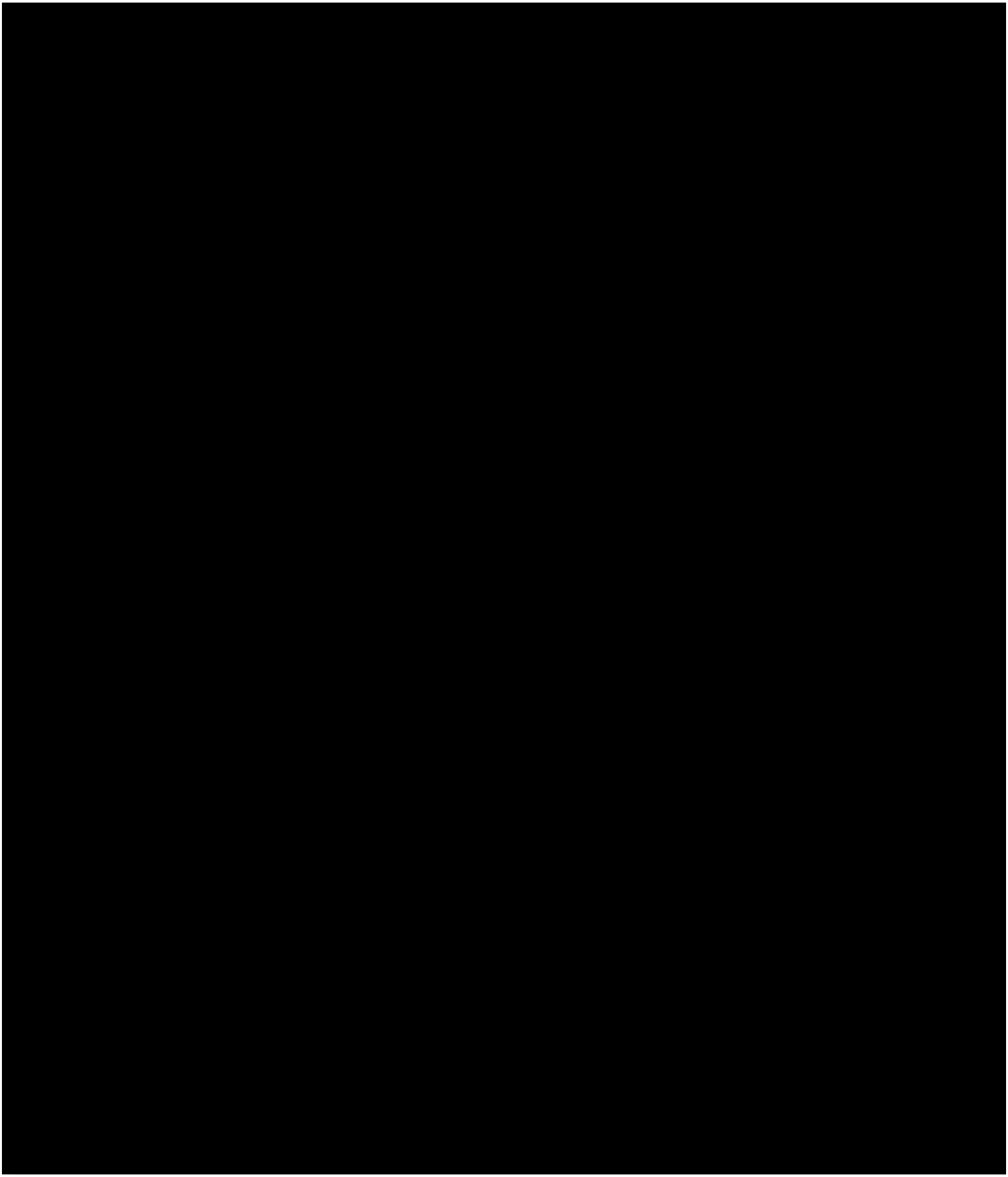

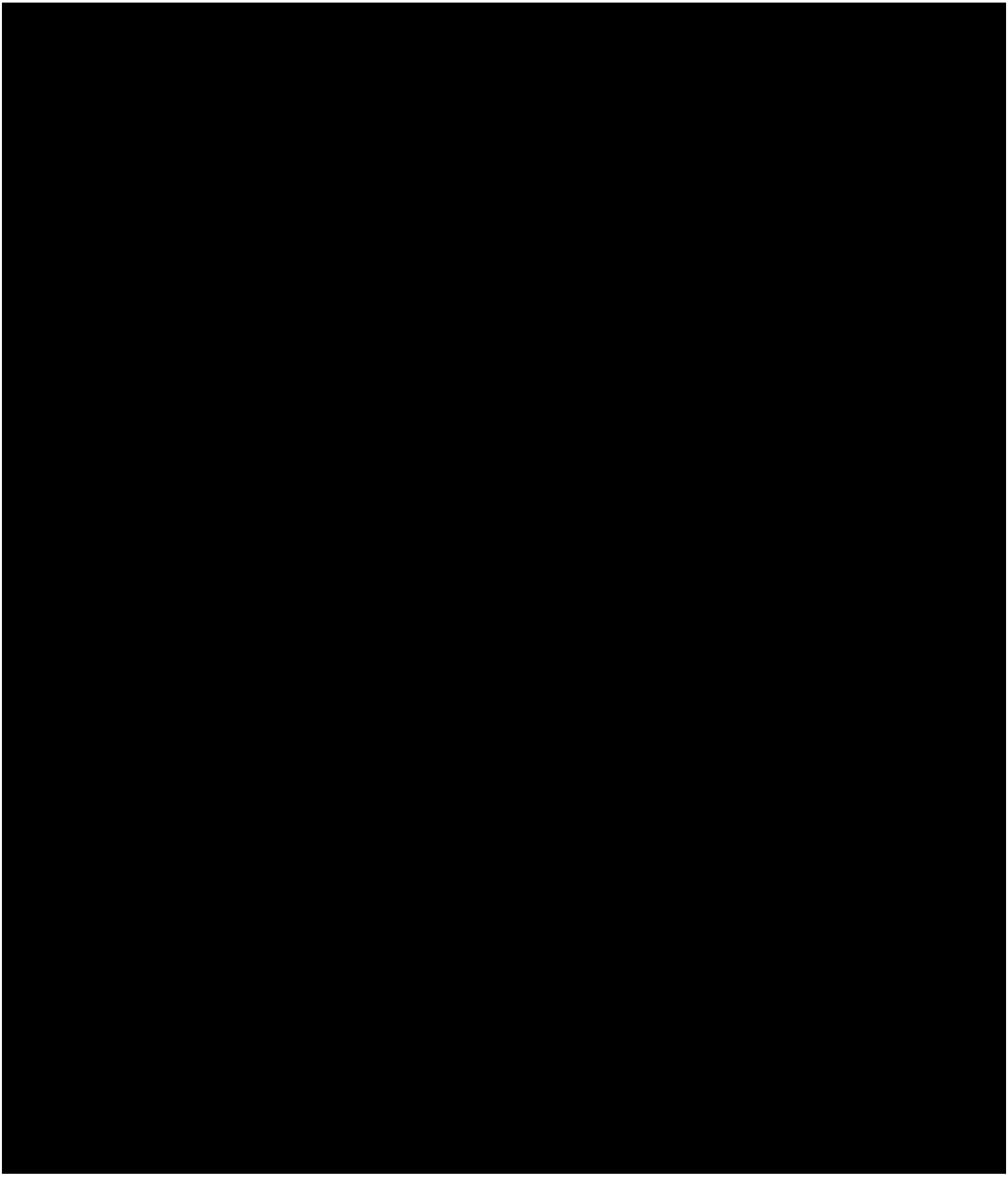

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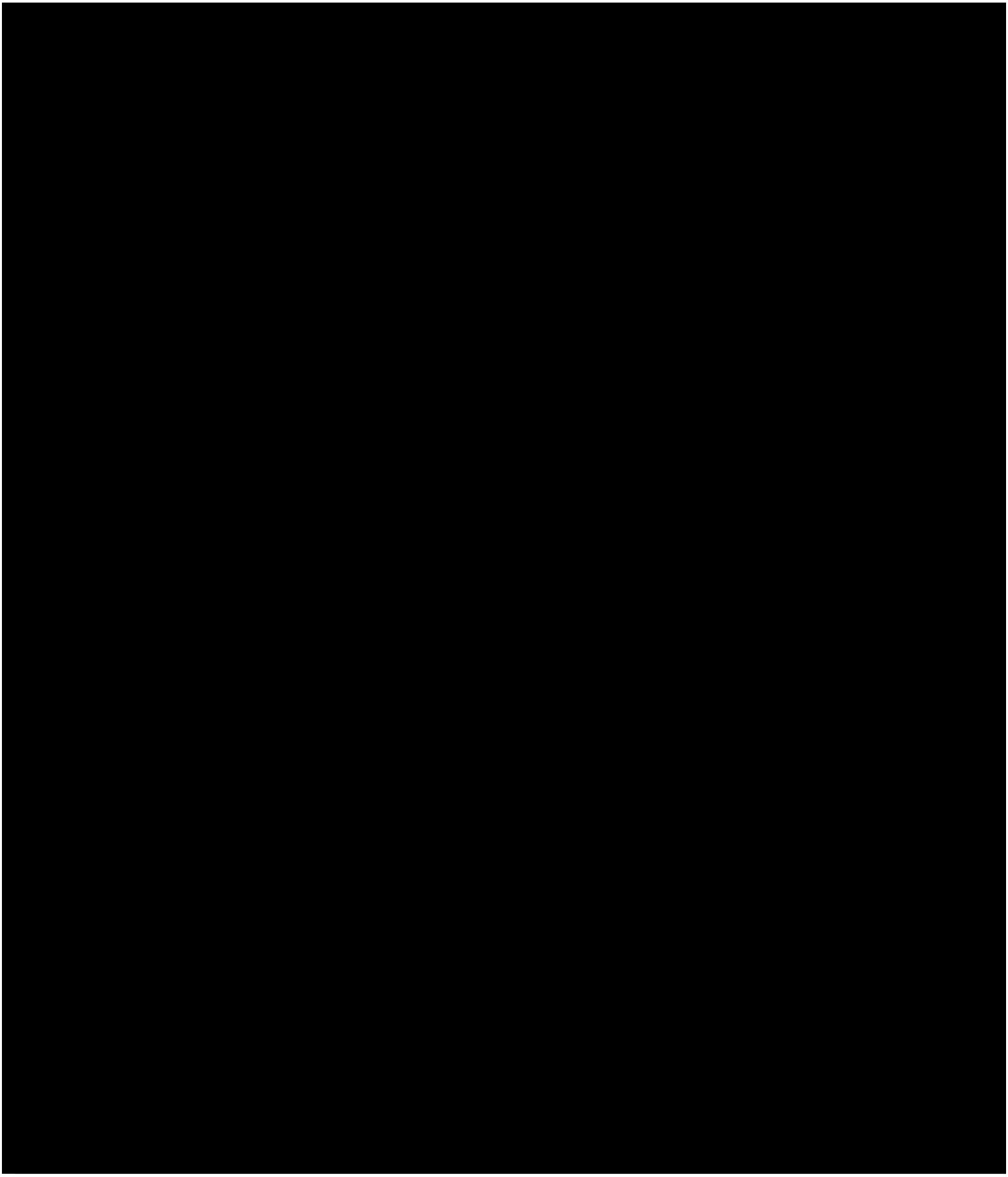
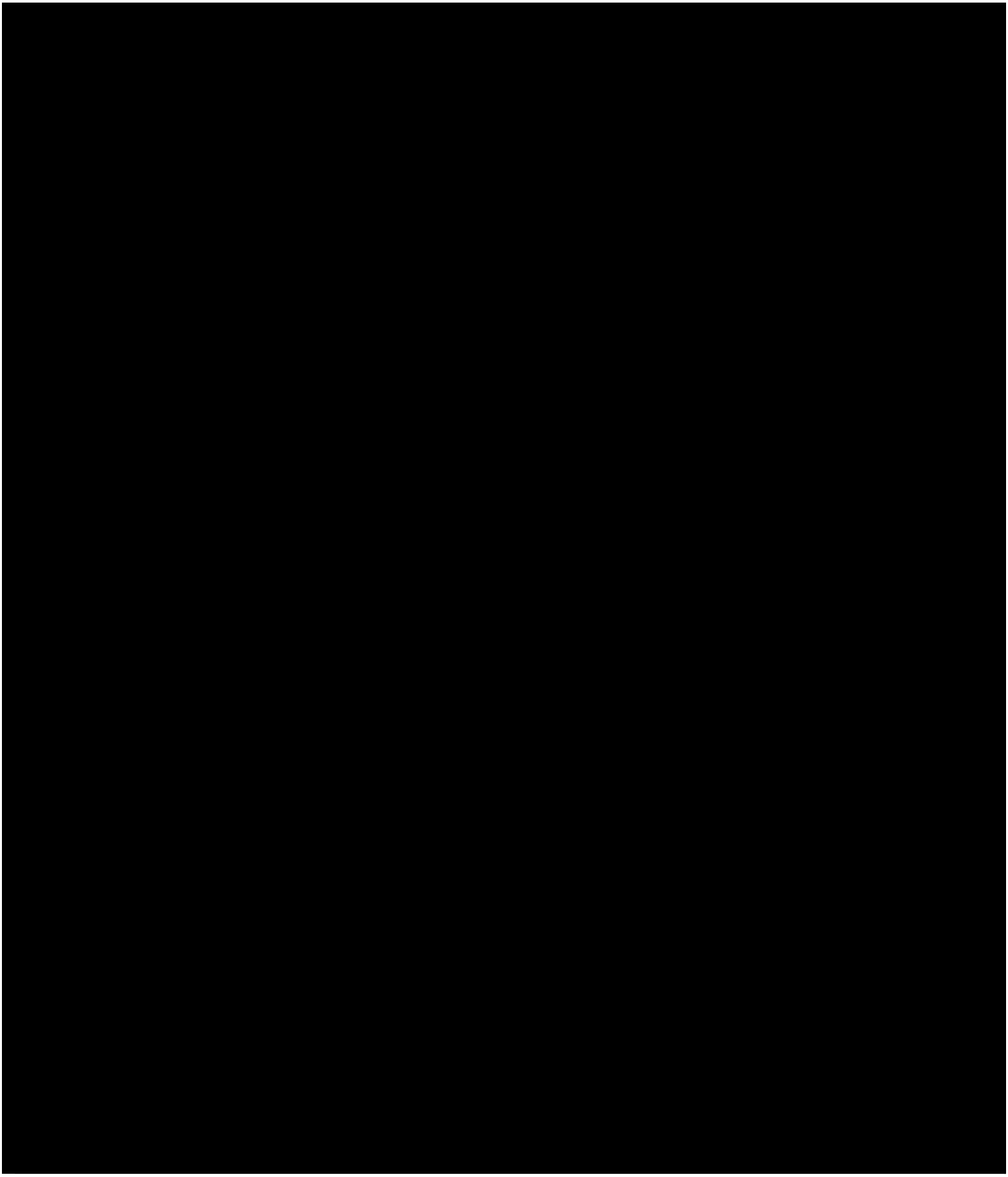
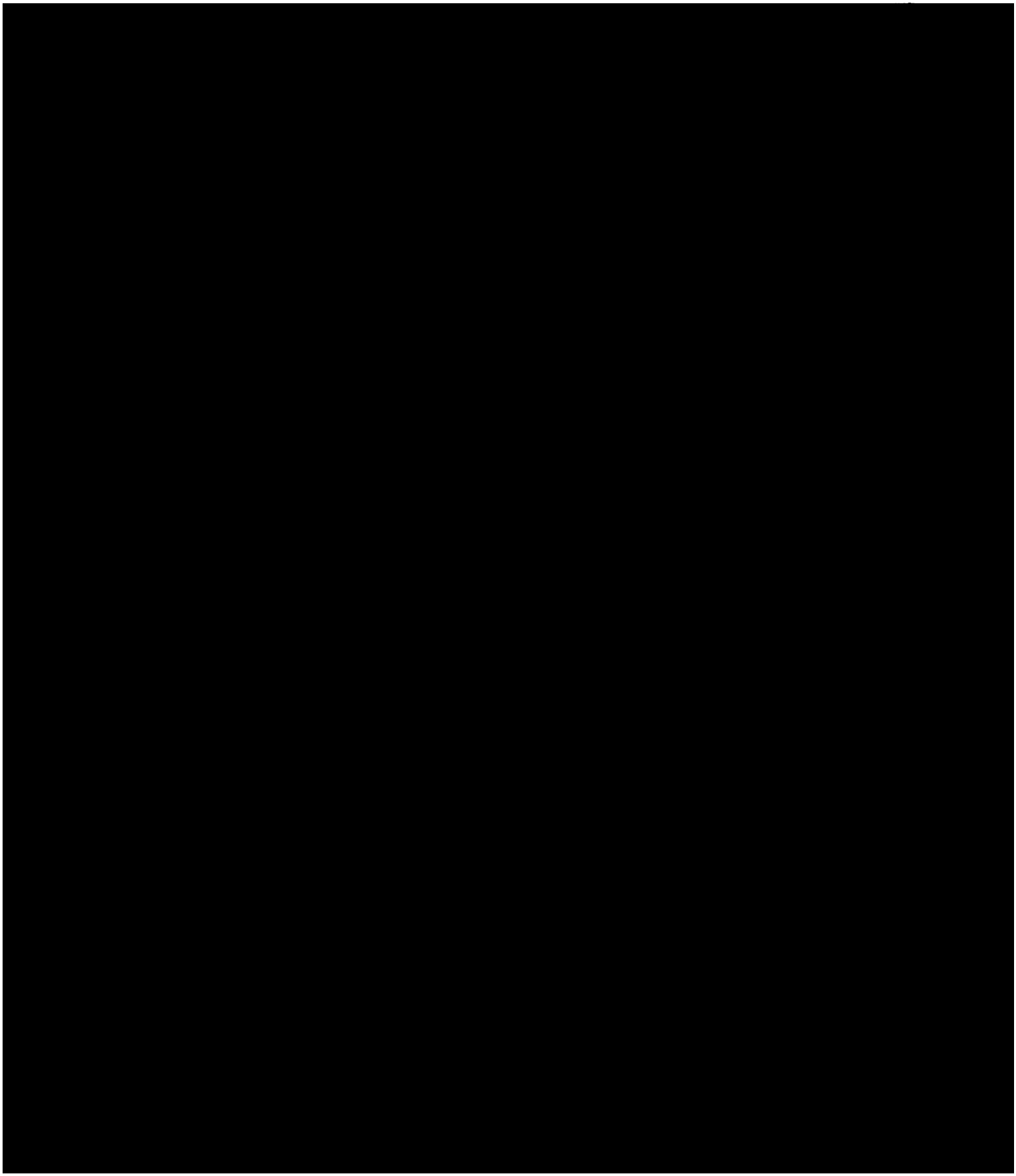






A Humana Healthy Horizons in Louisiana associate volunteering at the Makin' Groceries Mobile Market event. Humana sponsors the Makin' Groceries Mobile Market, improving access to food and essential resources in rural communities across Acadiana.

Section 2.6

Technical Proposal

Humana

Healthy Horizons™
in Louisiana

Matthew Berger, Humana Medicare Regional President, addresses the crowd during the launch of the Makin' Groceries event in Lafayette, LA, July 23, 2021.

Humana sponsors Makin' Groceries Mobile Market, improving access to food and essential resources in rural communities across Acadiana.

Section 2.6.2

Proposer Organization and Experience

Humana

Healthy Horizons™ in Louisiana

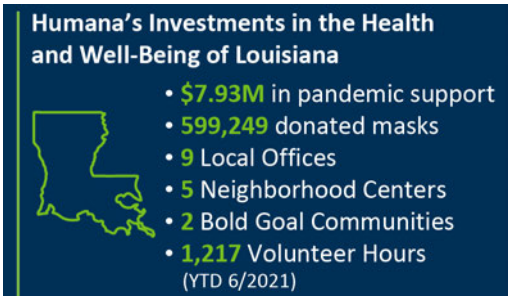
2.6.2.1 2.6.2.1 Proposer Organization

Healthy Louisiana will benefit from the breadth of experience that Humana Health Benefit Plan of Louisiana, marketed as Humana Healthy Horizons™ in Louisiana, its parent organization, Humana Inc., and its affiliate health plans (Humana), has developed in its six decades in healthcare. Our agile organizational structure under the guidance of qualified local leadership will support Louisiana Department of Health's (LDH) programmatic goals.

2.6.2.1.1 History of Humana and Its Parent Organization

An experienced health care company, Humana's beginnings as a nursing home facility in 1961 shaped how we manage statewide-managed care programs and how we will support LDH in achieving its Medicaid goals. Taking care of the vulnerable is in our DNA. We later transitioned from nursing homes into hospital operations and became the largest hospital company in the country. By the 1980s, we moved into managed healthcare. Today, we cover nearly 17 million enrollees across Medicaid, Medicare, TRICARE, and Commercial plans. We have continuously operated Medicaid Managed Care plans since 1994 and currently serve nearly 900,000 Medicaid enrollees nationwide. We have remained true to our core values to support the health and well-being of our enrollees, thanks in no small part to associates that practice and promote our values in every aspect of their roles.

Humana's Service to Louisiana: 36 Years and Counting



Humana has been an integral part of Louisiana healthcare since 1985. We currently manage care for nearly 215,000 Medicare Advantage (MA) enrollees, including more than 40,000 Medicaid enrollees on Dual Eligible Special Needs Plans (D-SNP); nearly 51,000 Medicare Part D Prescription Drug Plan (PDP) enrollees; 39,000 commercial enrollees; and more than 124,000 TRICARE enrollees. Our enrollees are in all 64 parishes, supported by nine offices, five Neighborhood Centers, and more than 1,000 associates across the State. We give back to Louisiana communities through charitable donations, hurricane and pandemic relief, and associate volunteerism. With more than 450,000 enrollees within the state of Louisiana across all lines of business, Humana has a keen understanding of the local healthcare landscape. We have developed strong relationships with Louisiana community groups, providers, corporate partners, and government agencies.

Humana's Organizational Goals and the Relevant Medicaid Managed Care to Humana's Mission

Our mission is to help people achieve lifelong well-being. Central to this is Bold Goal, one of our key population health strategies designed to co-create evidence-based, scalable, and financially sustainable solutions with community-based organizations and providers. With Medicaid covering more people than ever before, Medicaid populations are central to our **Bold Goal to improve the health of the communities we serve**. We collaborate with a wide range of local stakeholders to solve systemic problems and address social determinants of health (SDOH). Baton Rouge and New Orleans are among the original seven Bold Goals markets nationwide when Bold Goal launched in 2014. We are expanding Bold Goal across Louisiana to enhance our community partners' reach and impact which is very crucial during the COVID-19 pandemic, as families deal with food insecurity, access to care, and social isolation. **In Louisiana, Humana invested $7.93 million to support community organizations in their overall mission to ensure they could continue operations during the pandemic, including nearly 600,000 masks.**

Our Bold Goal aligns with LDH's priorities for SDOH and health equity, removing or minimizing barriers that hinder enrollees' progress toward good health. LDH, together with an experienced partner like Humana, can continue to adapt to changes brought on by pandemics, evolving healthcare concerns, and natural disasters, using those lessons learned to keep Louisiana prepared for the unexpected.

Volume of Medicaid Business and States Supported

Humana supports nearly 900,000 Medicaid enrollees in Florida, Illinois, Kentucky, South Carolina, and Wisconsin.

2.6.2.1.2 Humana's Medicaid Managed Care Contracts

As our Medicaid Managed Care (MMC) experience demonstrates, Humana has managed complex populations at industry-leading levels of quality for many years for a diverse range of demographics and populations, as reflected in **Table 2.6.2.1**.

Table 2.6.2.1: Humana's Medicaid Managed Care Contracts over the Last Seven Years

Contract	Enrollees	Populations Served	Current Contract Dates (Initial contract year)
Florida Statewide Medicaid Managed Care - Comprehensive Contract including Managed Medical Assistance and Long-Term Care	624,808	TANF; CHIP; ABD; I/DD; foster care children; SMI; Dual-eligible; Long-term Services and Supports(LTSS)-eligible	August 1, 2018-January 1, 2024 (2013)
Illinois Integrated Care Program	5,226	Non Dual Disabled	2014-2017
Illinois Medicare-Medicaid Alignment Initiative	10,029	Dual Eligible	January 1, 2020-December 31, 2022 (2014)
Kentucky Medicaid Managed Care	168,844	TANF; CHIP; ABD, Expansion; Dual-eligible	January 1, 2021 - December 31, 2021 (2013)
South Carolina Healthy Connections	1,021	TANF; CHIP; ABD; SSI	July 1, 2021 - Ongoing
Virginia Commonwealth Coordinated Care	9,143	ABD; Dual-Eligible	2014-2017
Wisconsin Medicaid Managed Care • BadgerCare Plus • Medicaid SSI • Family Care Partnership	 • 28,682 • 10,631 • 1,324	 • TANF; CHIP; • SSI; ABD • ABD; w/ and w/out Medicare; LTSS-eligible	 • January 1, 2020-Ongoing (2008) • January 1, 2020-Ongoing (2008) • Regions 3, 11: January 1, 2018-December 31, 2023 Regions 8, 12: January 1, 2019-December 31, 2024 (2010**)
*Membership at the end of the contract period		**original contract was for Region 8	

Experience in Providing Healthcare Services for a Medicaid Managed Care Program

Humana has more than the required minimum of seven years of experience in MMC. One of our earliest programs was our Florida Medicaid Health Management Organization contract that began in 1997. We serve nearly 900,000 Medicaid beneficiaries, including more than 500,000 D-SNP members in 26 states and Puerto Rico, including more than 40,000 in Louisiana.

> Humana operates 42 NCQA-accredited health plans across our Medicaid, Medicare Advantage, and commercial lines of business, including two NCQA-accredited plans in Louisiana.

Contracts Engaged in or Awarded Within the Last 12 Months with over 1.5 Million Enrollees

As described above, Humana has Medicaid managed care contracts in Florida and Kentucky, and was recently awarded a Medicaid managed care contract in Ohio. All three states cover more than 1.5 million Medicaid enrollees each.

2.6.2.1.3 Noncompliance Actions

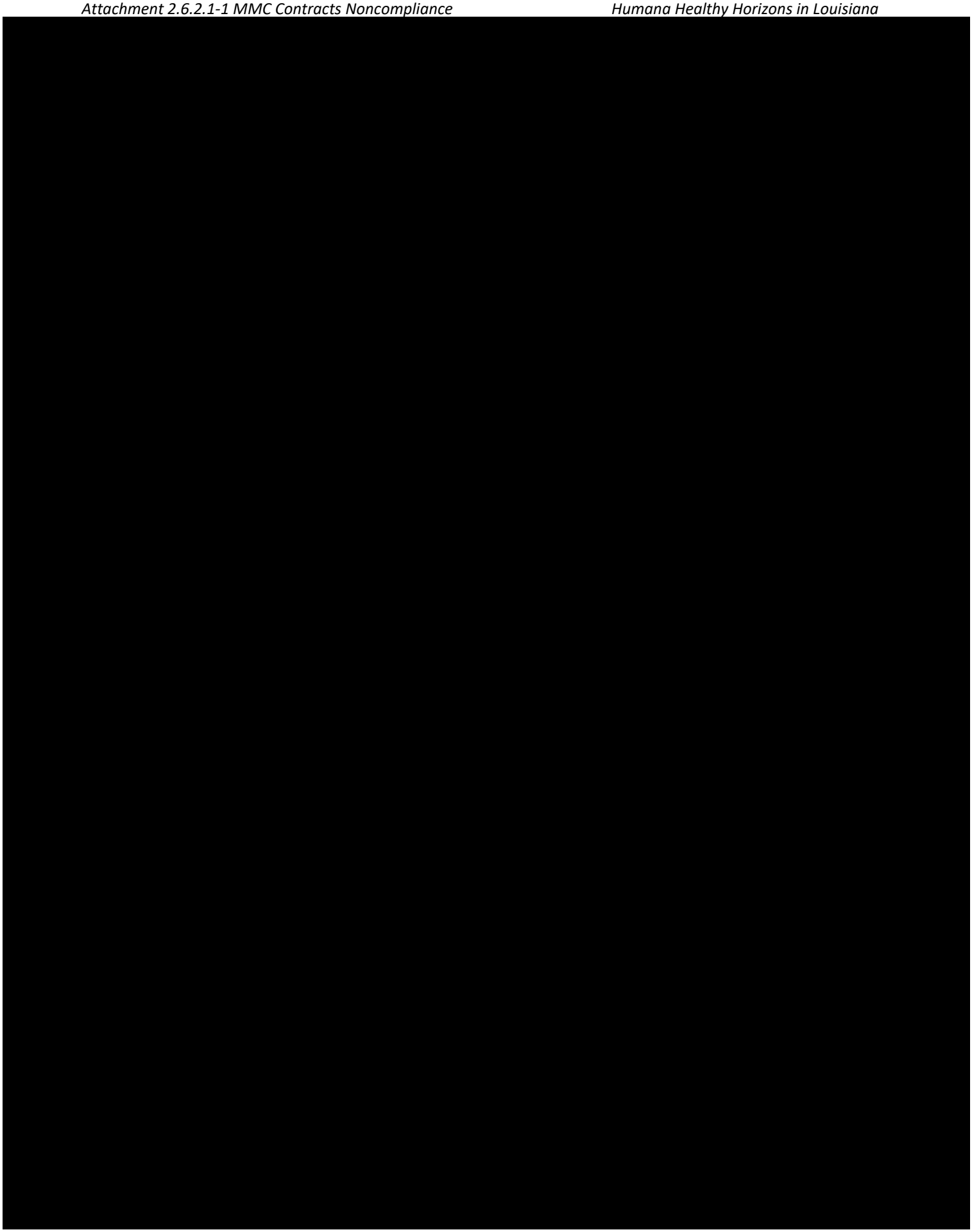
Please refer to **Attachment 2.6.2.1-1** for MMC Contracts noncompliance.

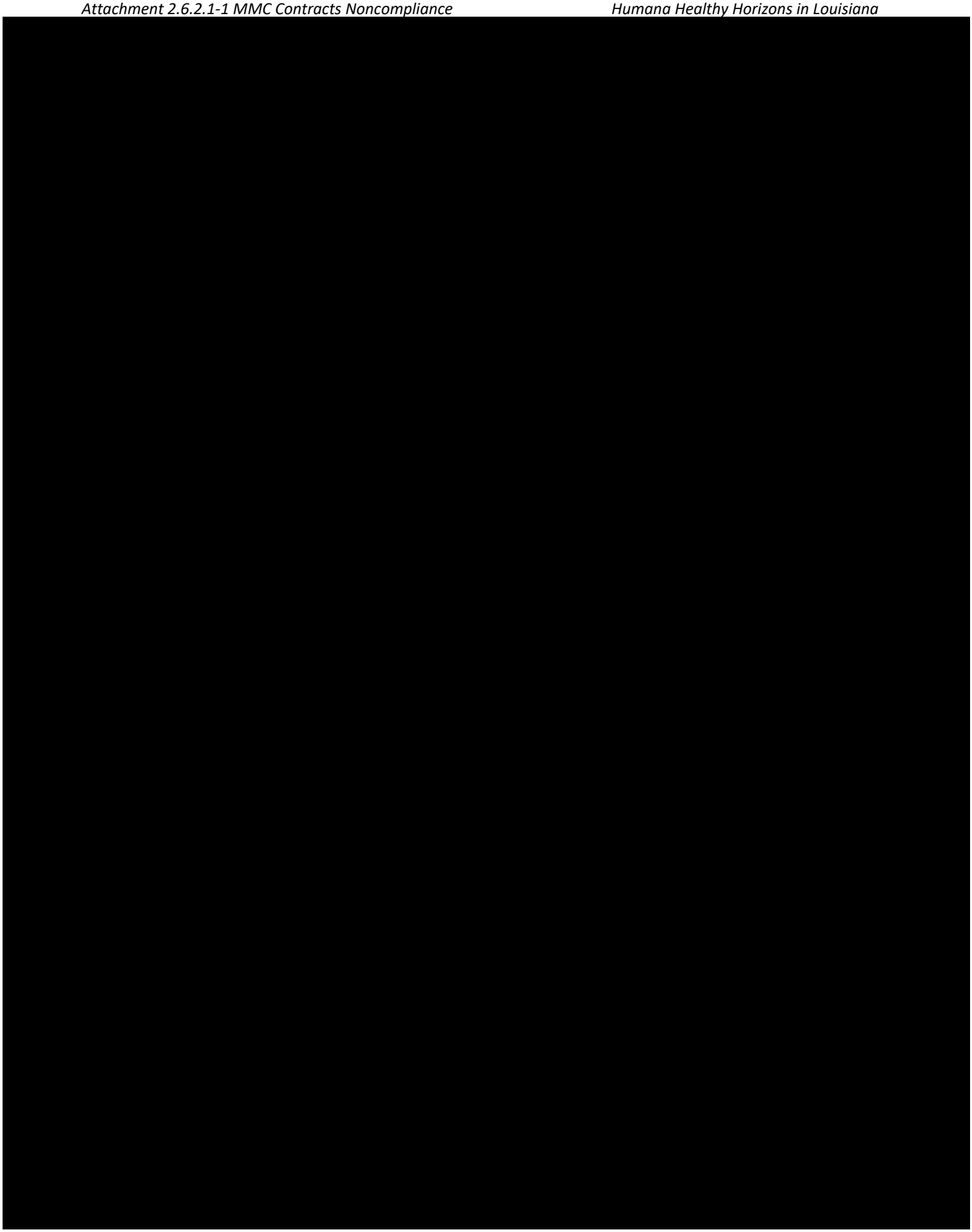
2.6.2.1.4 Contracts Terminated or Not Renewed Prior to Contract End Date

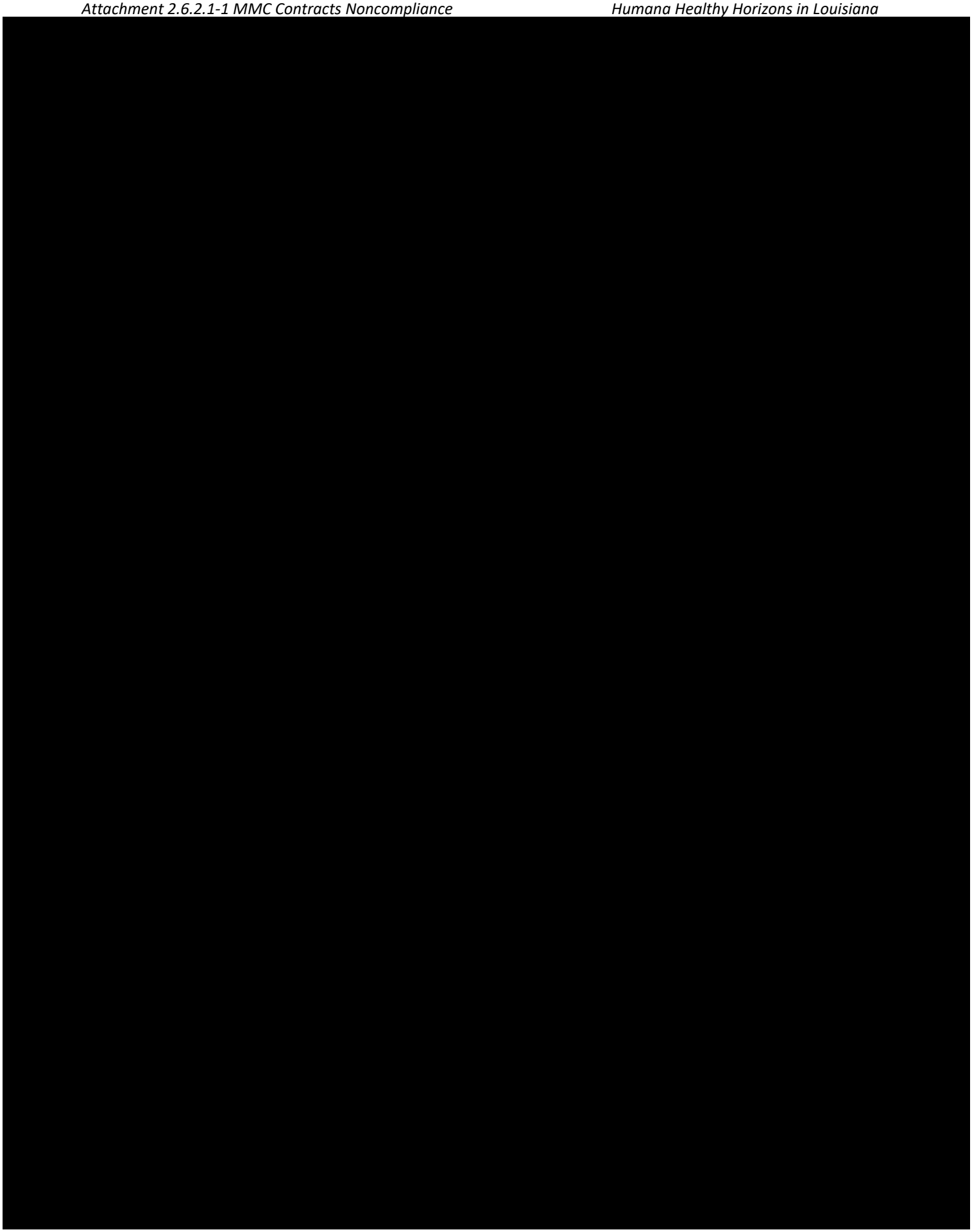
Humana Health Benefit Plan of Louisiana, its parent company Humana Inc., and its related affiliates have no terminated contracts to disclose.

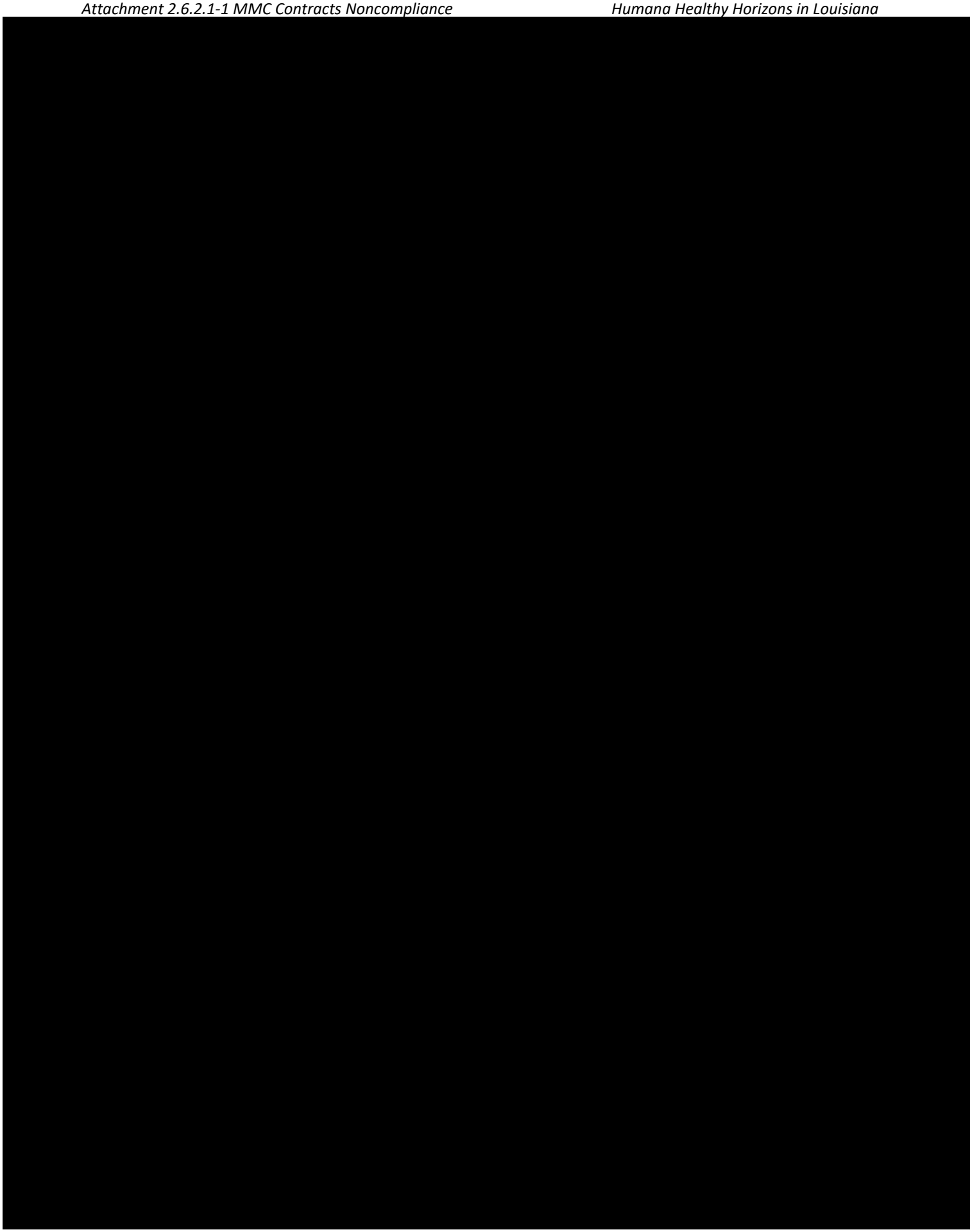
2.6.2.1 Proposer Organization

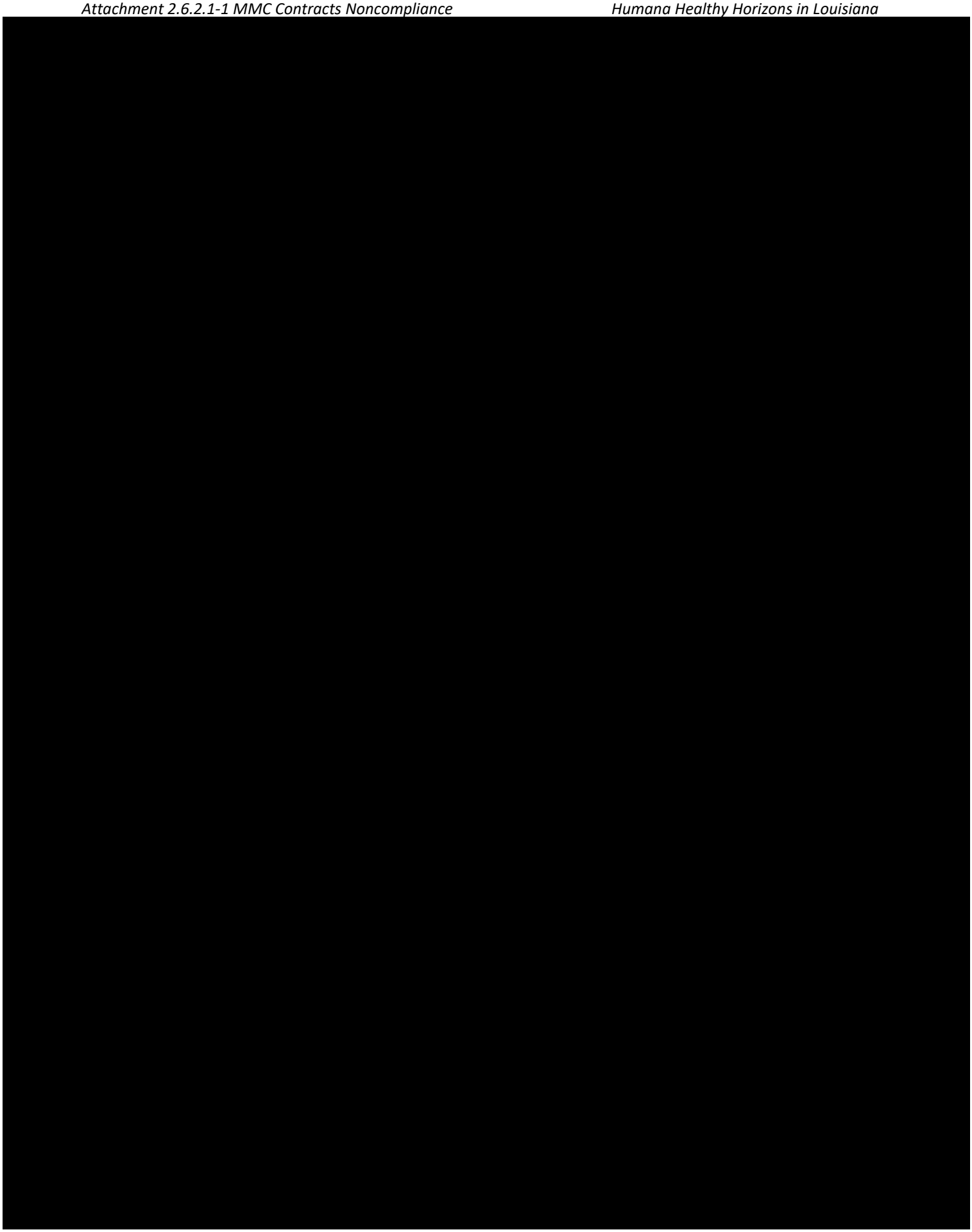
Attachment 2.6.2.1-1 MMC Contracts Noncompliance

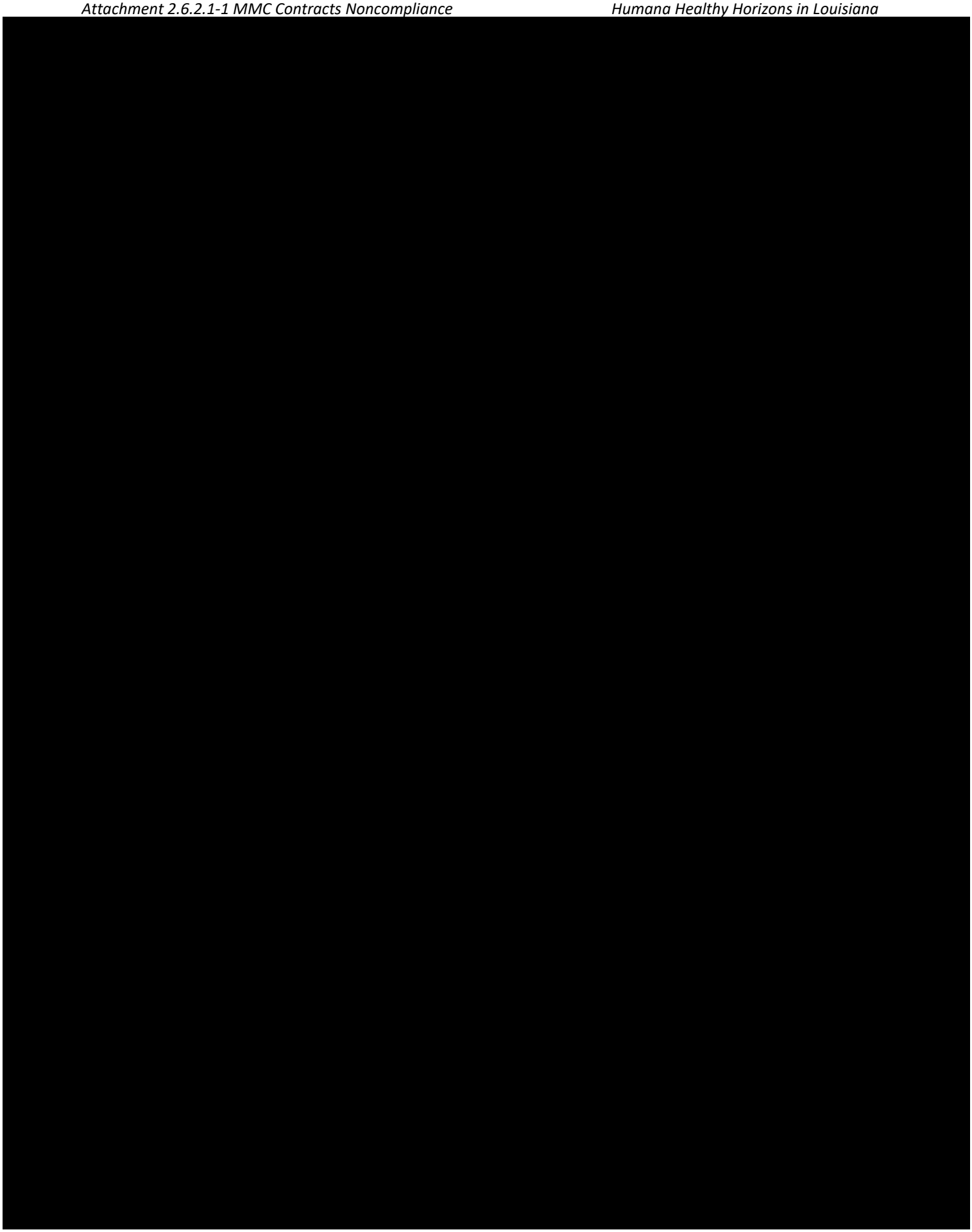


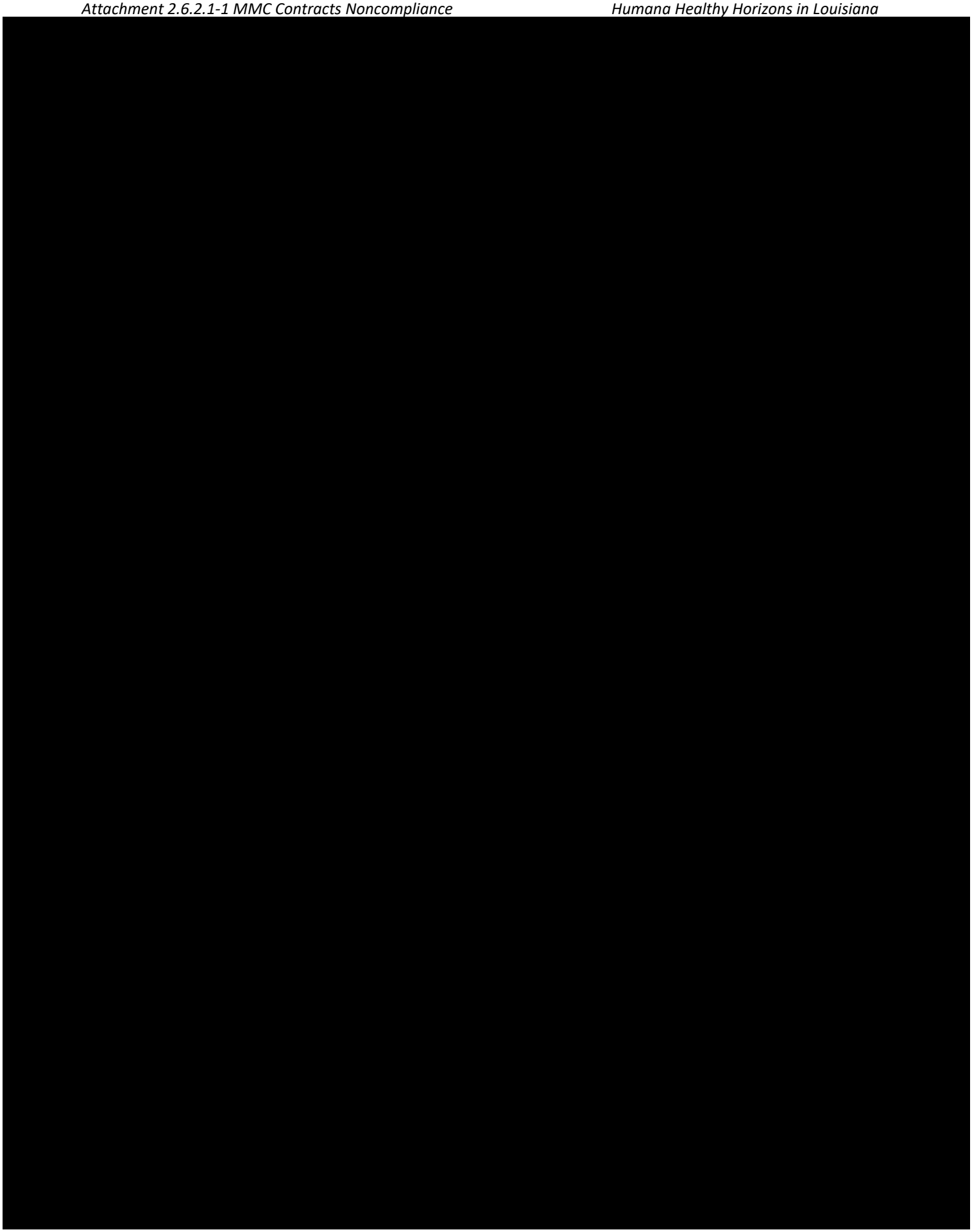


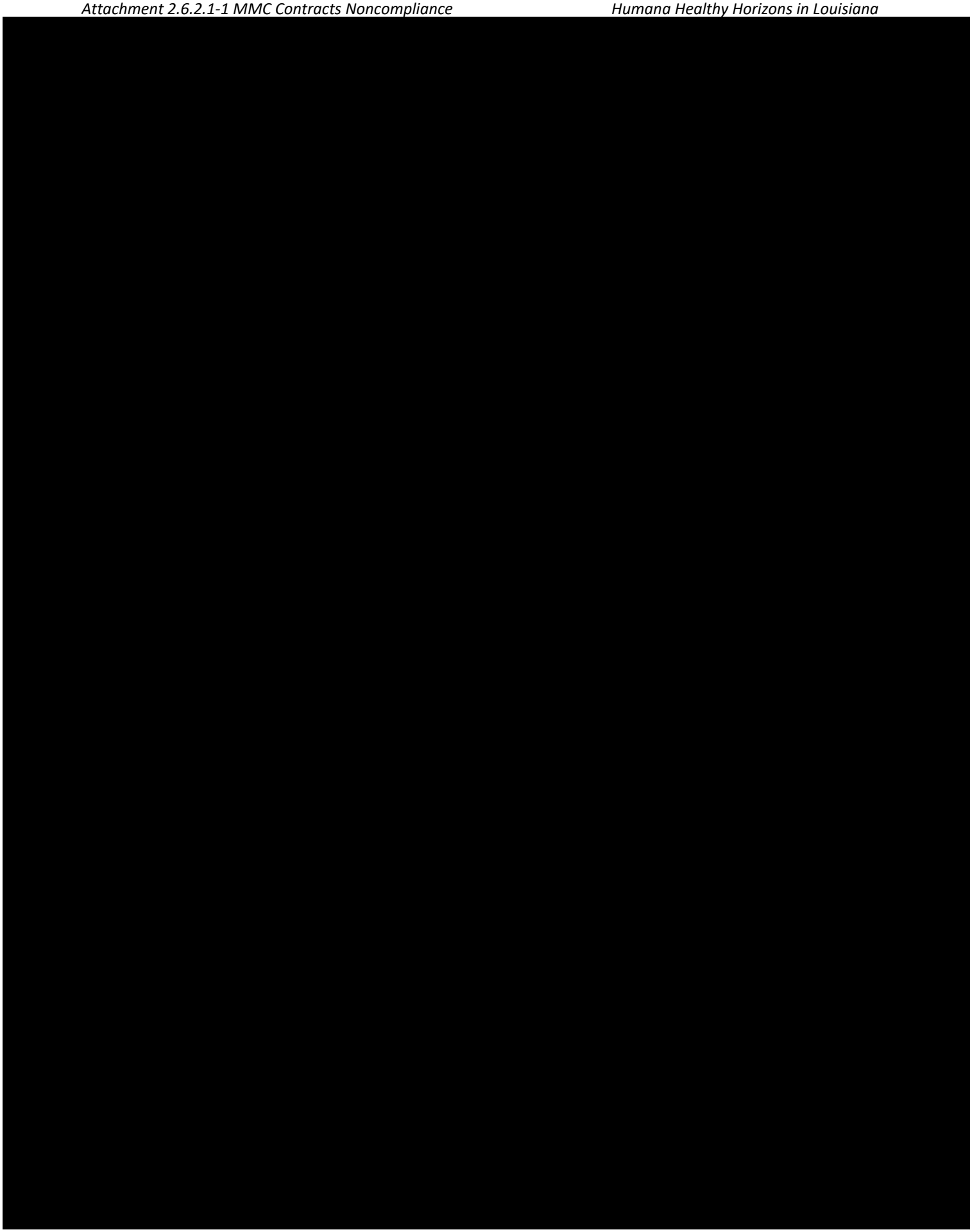


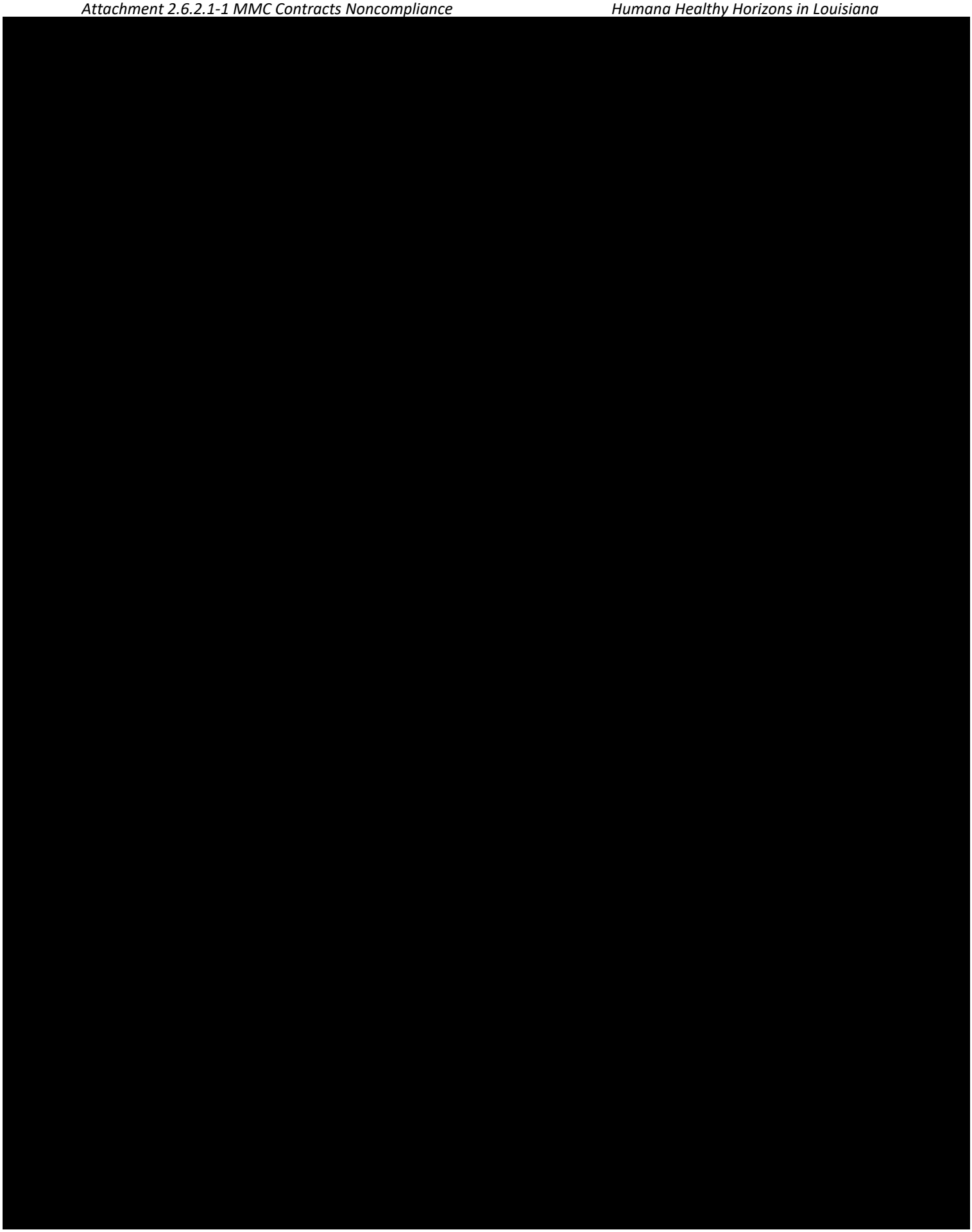












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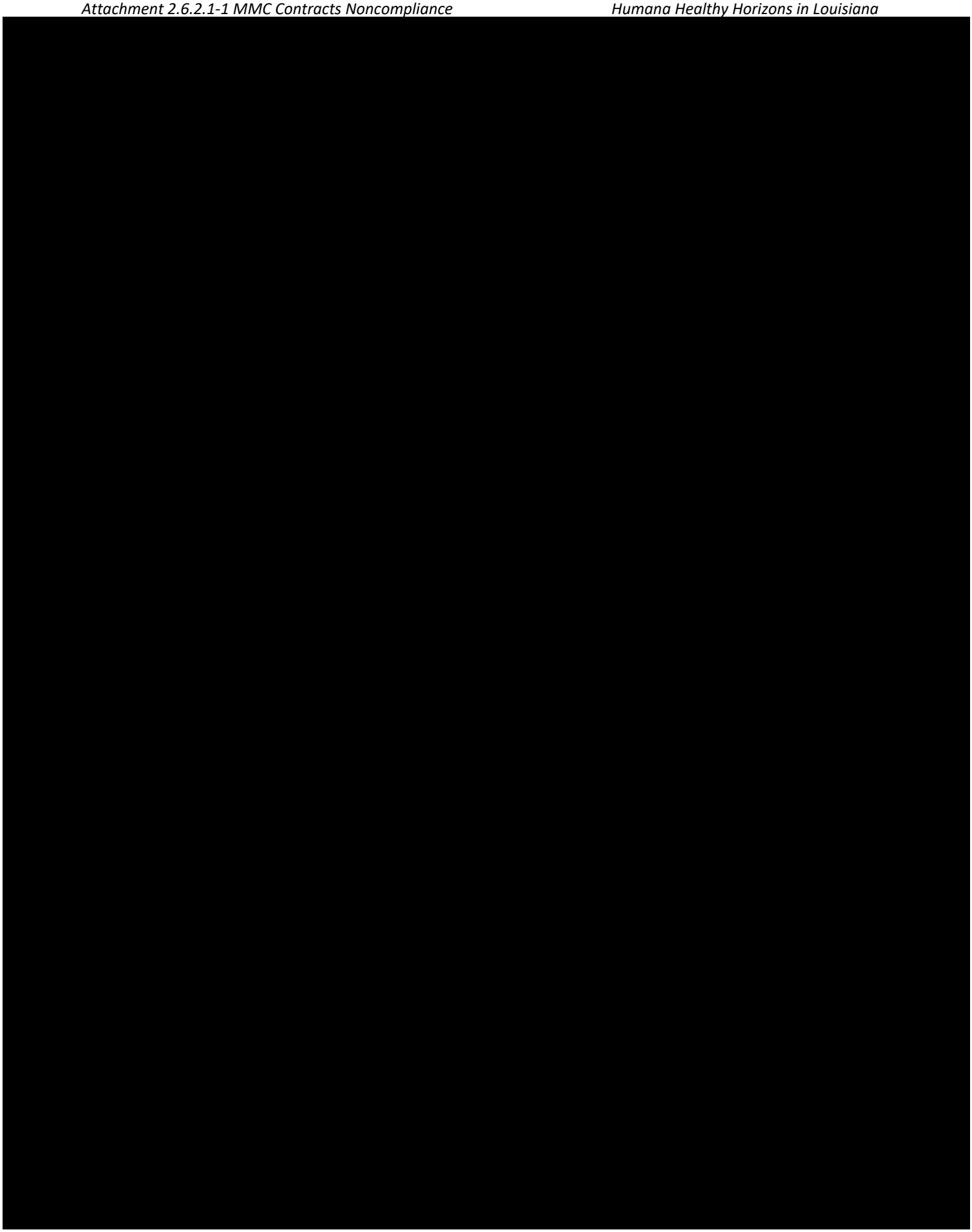

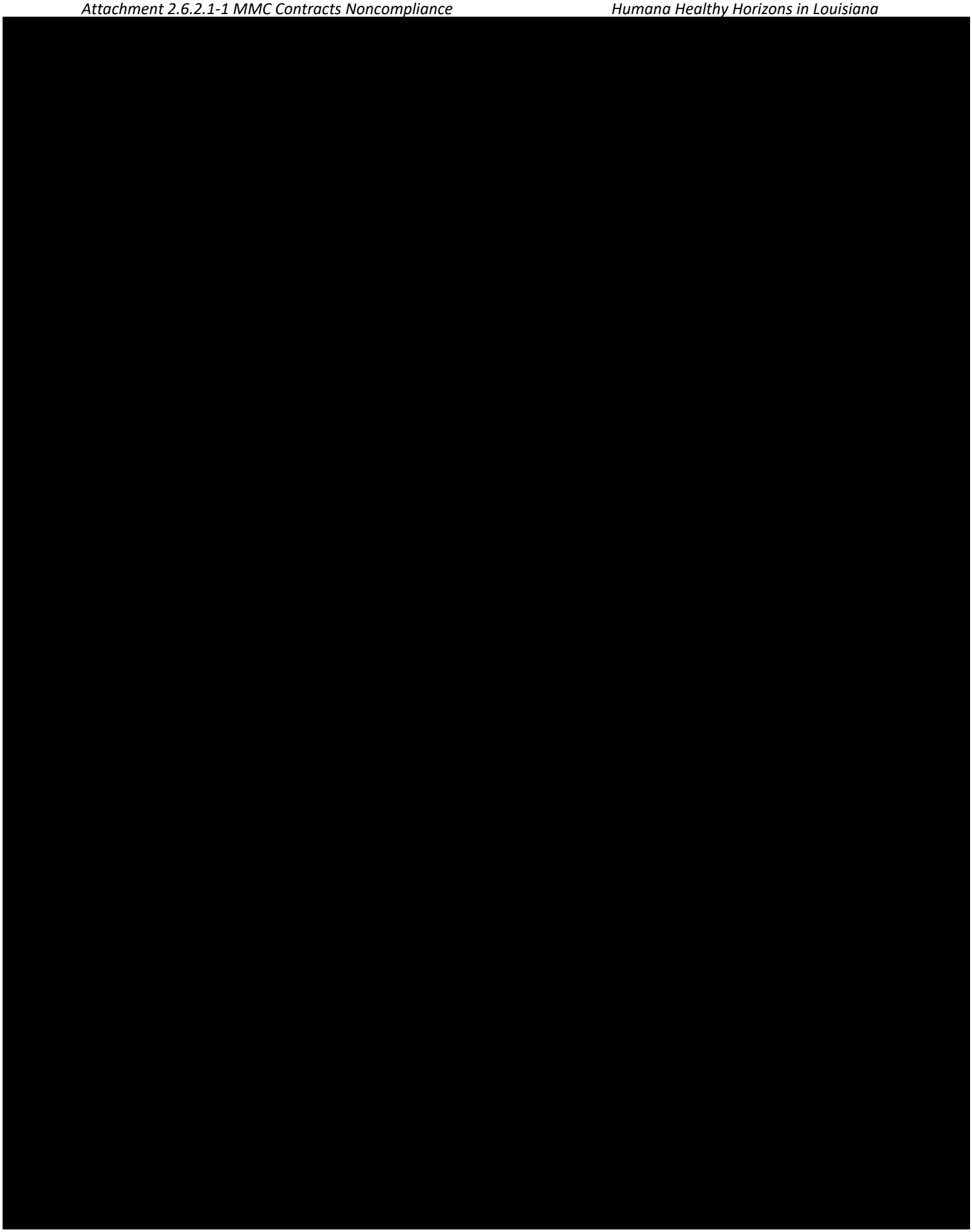

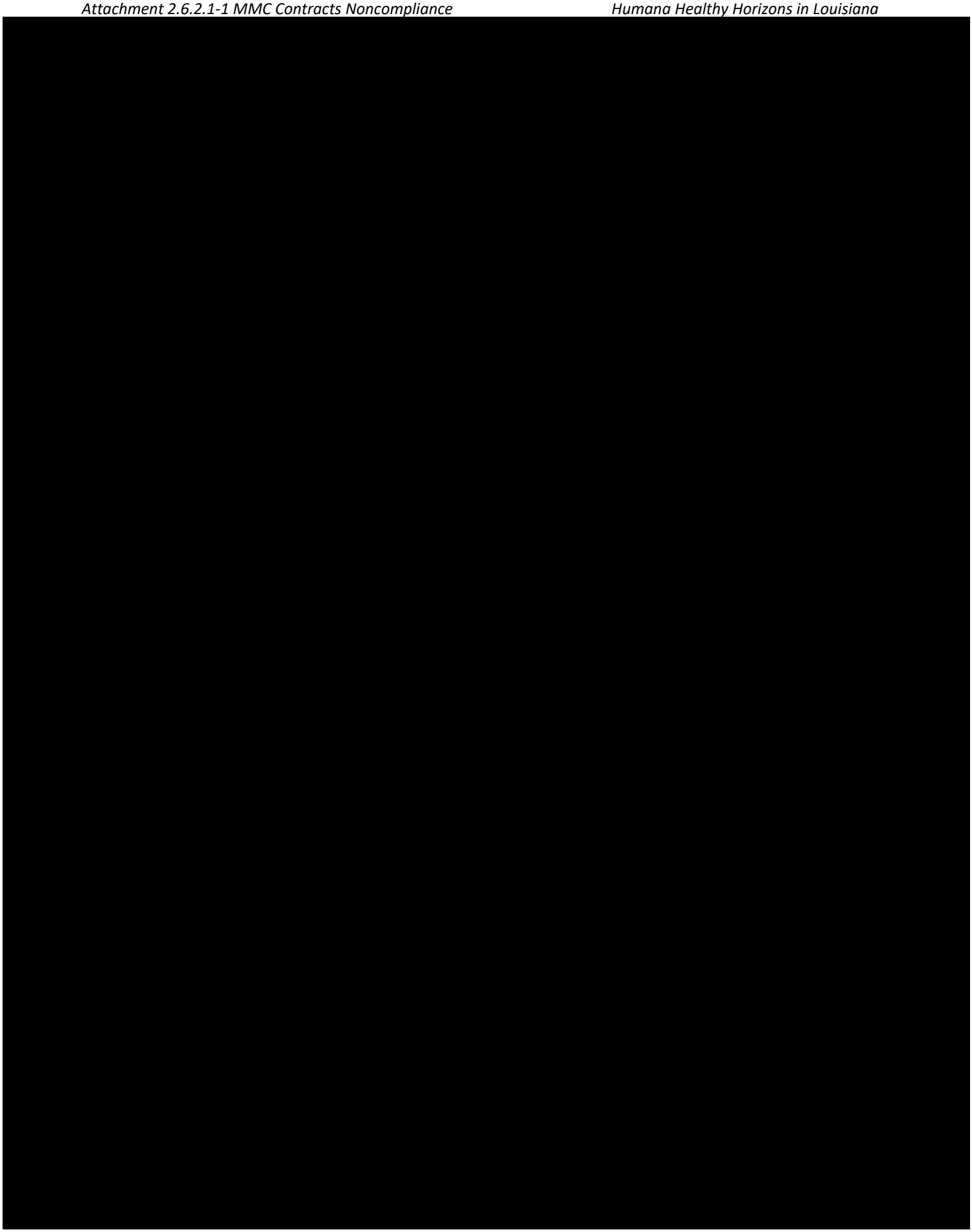

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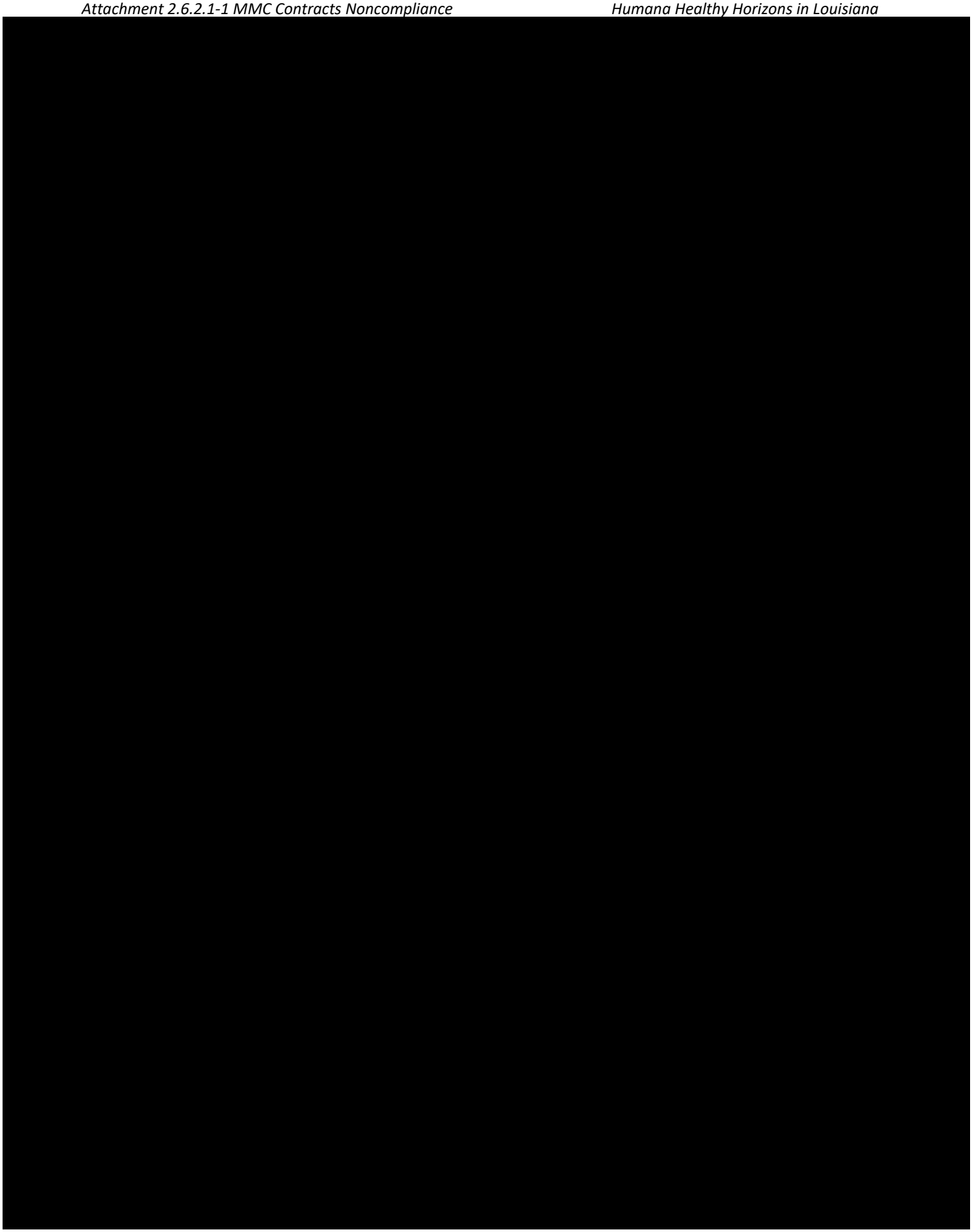
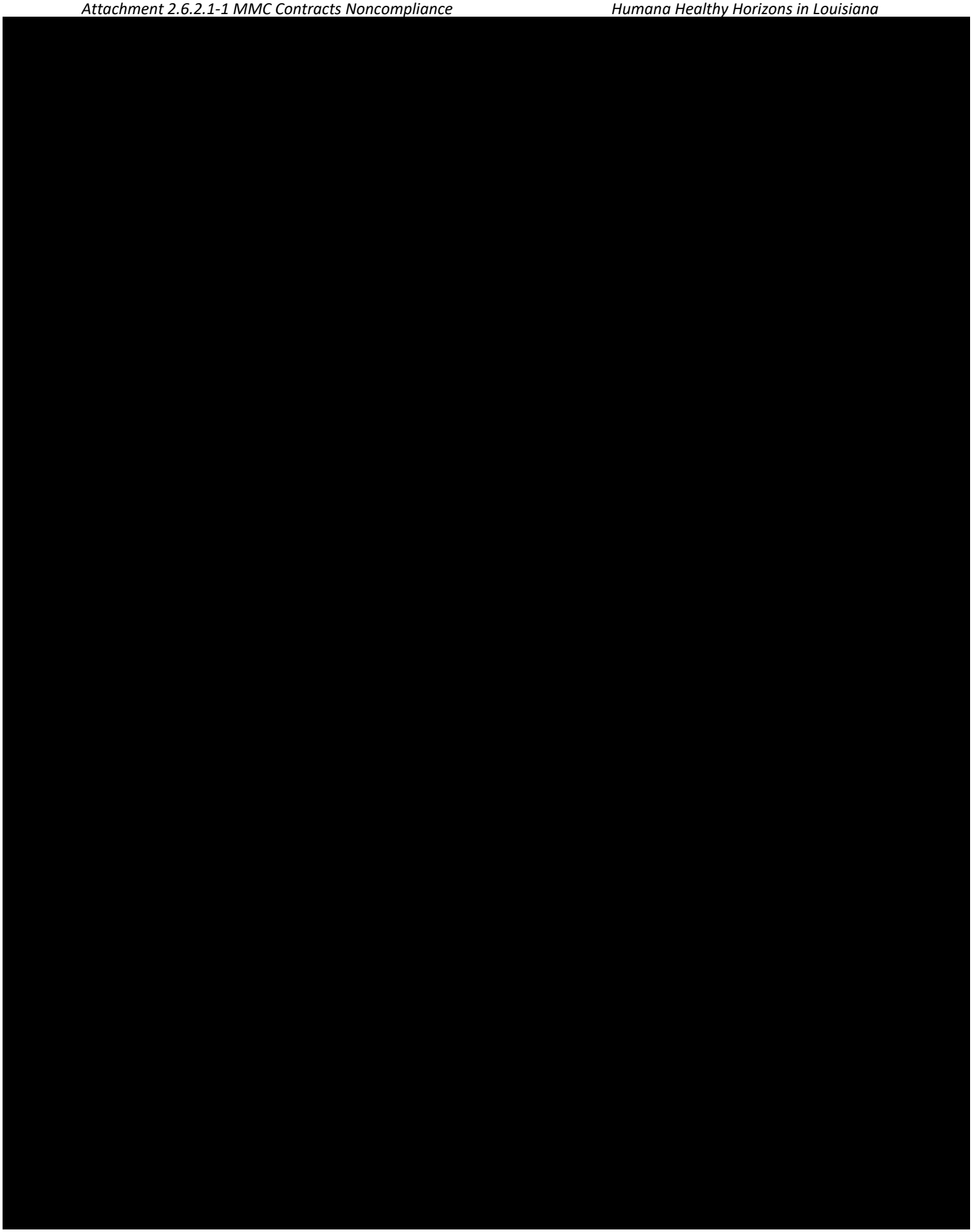
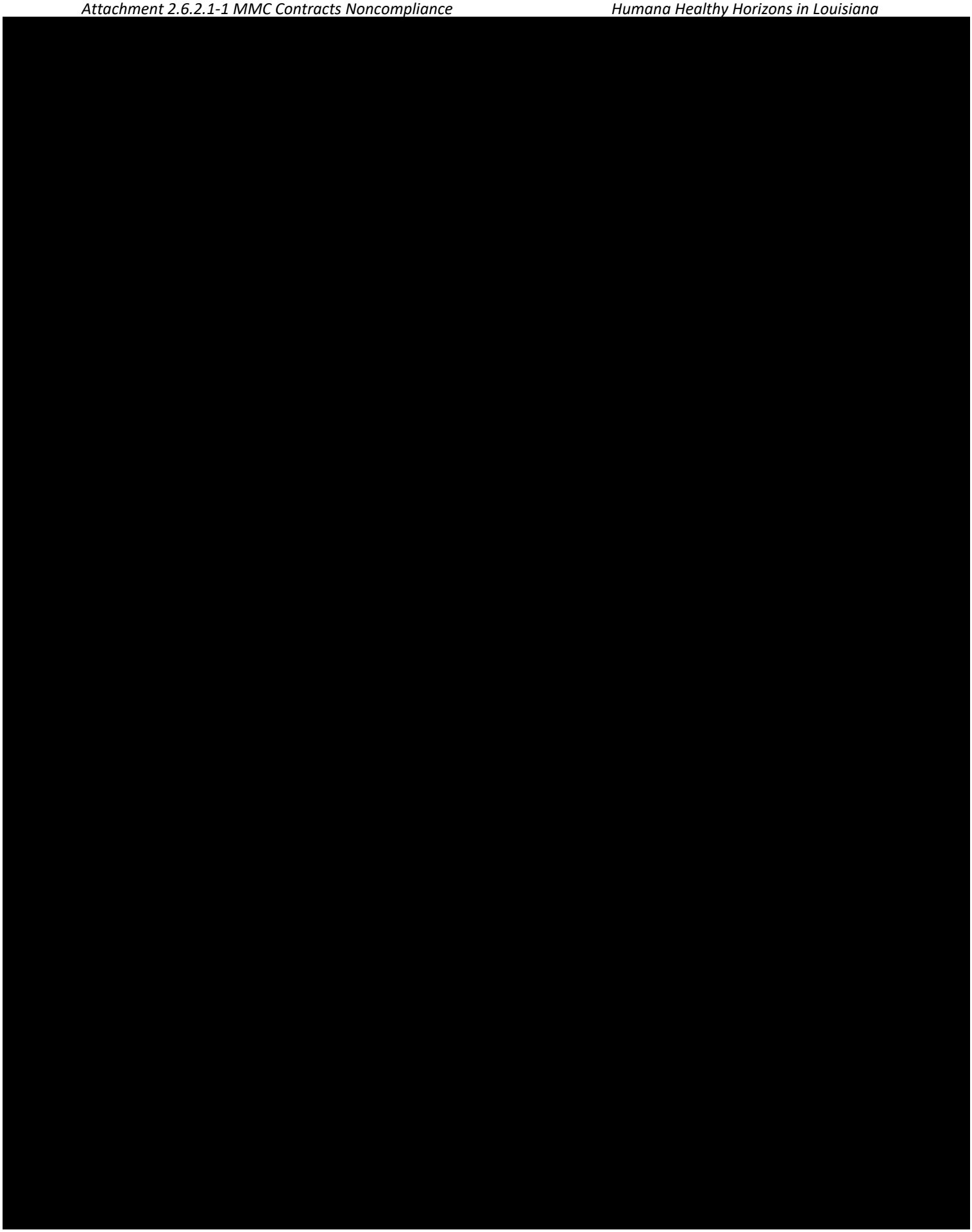






2.6.2.2 Humana Healthy Horizons in Louisiana Proposed Staff Qualifications and Organizational Structure

Humana Healthy Horizons in Louisiana's key personnel and staff are qualified and trained to support Healthy Louisiana, and encourage diversity and inclusion across the organization. We have reviewed and confirm adherence to the requirements in **Model Contract Section 2.2.2.**

2.6.2.2.1 Identifying Key Personnel

Key personnel shape the direction of Humana's operations and our teams. Humana Healthy Horizons in Louisiana's [redacted], has decision-making authority at the plan level and collaborates with our Human Resources, Diverse Talent Strategy, and Recruiting teams to select key personnel that will best support clinical and service delivery excellence for Louisiana.

We vet each candidate for appropriate qualifications and experience as well as any criminal actions or healthcare program disbarments. Once hired, candidates undergo job- and Louisiana-specific training, including mandatory Ethics and Compliance training. We emphasize hiring candidates with local expertise who are deeply invested in issues important to the community. In our three largest markets, Florida, Kentucky, and Wisconsin, our leaders average 30 years of living and working in their local communities. Humana's Diverse Talent Strategy team promotes a diverse workforce, including sourcing through colleges and universities, associate referrals, community groups, targeted job board and social media postings, advertisements, and cross-industry organizations. The wealth of accolades we receive each year is testament to our commitment to a collaborative, inclusive workforce.

Prior to the pandemic, we developed strategies to support Humana associates that work from home to maximize flexibility and responsiveness. The evolution of these efforts is **WorkLife Reimagined**. This initiative offers home, office, field, and hybrid workstyles, improving associates' ability to direct their careers, promoting organizational agility, and meeting enrollees where they are.

In preparation for LDH's 2019 RFP and Humana's subsequent award, we sourced and hired a full roster of staff. **Following the award cancellation, we offered those associates the opportunity to transition to other business areas where they could develop Medicaid knowledge and skills useful to a future Louisiana contract**. As we refine staffing for this contract post-award, our intent is to transition these associates working on the new Louisiana Medicaid contract. [redacted]

Management Structure and Organization

The management structure for our key teams and units is rooted in local decision-making and oversight. The CEO leads the Executive Management team, which comprises key personnel along with additional roles necessary for programmatic success. The Executive Management team has daily check-ins and weekly meetings to discuss performance, stakeholder feedback, and to address any challenges. This collaborative approach ensures that we align functional areas and work toward achieving program goals. We manage and operate primary functional areas for the plan from within the State, including the Call Center, Integrated Care Management, Provider and Enrollee Services, UM, and Quality.

Each unit/team lead reports to key personnel for appropriate oversight; the CEO has ultimate responsibility for the plan and adherence to LDH's requirements. [redacted]

[redacted]

To maintain streamlined functions across the organization, our local leadership receives support from our enterprise operations teams for shared services common to all Humana plans, including Information Technology, Legal, and Data Analytics. While operated nationally, these teams work closely with the Executive Management team to provide timely knowledge-sharing and support.

2.6.2.2 Key Personnel Names and Roles

We will base all key personnel, who will be 100% dedicated to the Contract and exclusive to their roles, in Louisiana. **Attachment 2.6.2.2-1** includes resumes for all required key personnel.

[redacted]

[redacted]

In addition to the required key personnel, we will support this Contract with personnel whose Medicaid and Louisiana-specific experience will further our goals for Healthy Louisiana.

- [redacted]

2.6.2.2.3 Operating Structure, Reporting and Governance with our Parent Organization

Our local plan and our parent organization will both support Healthy Louisiana, combining vast experience, leadership, and resources to promote efficient processes and knowledge sharing across the enterprise. This provides access to successful programs, initiatives, and pilots introduced in other states,

nationwide analytics to identify common trends, and best practices that provide consistency for enrollees, regardless of changes in their lives and locations.

Our Board of Directors is responsible for creating and enforcing by-laws, policies, code of conduct, and adherence to governmental regulations. Board Members are experts in managed care and in their specific fields. Our CEO and other key personnel routinely report to the Board on performance and areas for improvement. Members include national Medicaid President, John Barger and Humana Inc. CEO, Bruce Broussard. Per the **Model Contract**, we will provide LDH a list of Board members prior to go-live.

Reporting to Mr. Barger, [redacted] receives support from him as well as with other national leaders to maintain the quality that state partners expect and our enrollees deserve. Mr. Barger reports to Alan Wheatley, President of our National Retail Segment, including Medicaid and Medicare Advantage. Mr. Wheatley reports to Mr. Broussard, President and CEO of Humana Inc.

Members of the Executive Management team participate in committees to focus on issues related to their functional area. They also take part in our Louisiana Local Market Operating Committee (LMOC) biweekly to share knowledge, discuss strategies for continuous improvement; and assess reports from quality improvement, call centers, grievance and appeals, complaints, as well as provider- and enrollee-focused committees. Mr. Mollica leads and represents the LMOC at the Operations Steering Committee, where Medicaid leaders from across the organization discuss trends, opportunities, and challenges.

Operating Structure Organizational Chart

Our organizational chart, in **Attachment 2.6.2.2-2,** illustrates our functional areas and staff types, including reporting relationships, locations, and material subcontractors.

Key Teams: Staffing

Per **Section 2.2.2.5.2 of the Model Contract**, Humana will maintain greater than 50% of its staff within the State of Louisiana. **Table 2.6.2.2-2** highlights our key teams.

Table 2.6.2.2-2: Key Teams - Roles, Leaders, Operating Activities, Reporting Lines and FTE Counts

Team and FTE Count	Roles, Operating Activities and Qualifications/Competencies	Team Lead and Reporting Lines
Executive Leadership • 5 FTEs	• [redacted] Plan executive leaders are directly responsible for the day-to-day management of health plan operations. They work directly with leadership in the parent company to ensure access to corporate resources and industry best practices • Minimum of Bachelor or Master degree, and certifications relevant to the; CMO: physician licensed in Louisiana, three years medical specialty training, five years of post-training experience providing clinical services, and board certification in their specialty	[redacted] of healthcare leadership experience
Integrated Medical Management (Including UM, Prior Authorization, and Concurrent Review teams; for both behavioral and physical health) • 211 FTEs	• This team is responsible for following evidence-based guidelines to make coverage and medical necessity decisions about which physical and behavioral health services to authorize based on enrollees' unique conditions • Includes at least one Louisiana-licensed Registered Nurse (RN), Advanced Practice Registered Nurse (APRN), physician, or physician's assistant; sufficient number of Licensed Mental Health Professionals (available 24/7), including licensed addiction counselors; board-certified psychiatrist; board-certified addictionologist (available at least 10 hours/week) or qualified consultant; UM staff experienced and specifically assigned to children, youth,	[redacted]

Team and FTE Count	Roles, Operating Activities and Qualifications/Competencies	Team Lead and Reporting Lines
	adults, and older adults	[redacted]
Integrated Care Management • 271 FTEs	• This team identifies, engages, and manages enrollees who require Care Coordination and Case Management services for physical health, behavioral health, and social services, coordinating with our Comprehensive Care Support team to support enrollees with co-occurring, complex needs • Certification in treatment planning—with Treatment Planning Philosophy Training; cross trained staff grouped into specialists for specific physical health conditions, behavioral health, and specialized behavioral health; behavioral health and physical health Case Managers are co-located; Care Management associates necessary to support enrollees who meet target population criteria for Department of Justice agreement	
Quality • 22 FTEs	• This team leverages data analysis and performance metrics to direct activities for continuous process improvements. • Clinicians, RNs, behavioral health and other professionals with CPHQ or CHCQM certifications; experience in data and outcomes measurement, including data analysis, coding, claims, or performance measures (HEDIS, NCQA, etc.)	
Population Health • 26 FTEs	• This team works to identify specific, targeted opportunities for improved health outcomes to address gaps in care. They develop partnerships with community based organizations to improve program offerings that address SDOH needs for specific populations • Experienced professionals with knowledge and skills in SDOH, data analysis, statistics, clinical practice, population health, community health, and/or related fields	
Enrollee Services (Enrollee Call Center—inbound and outbound; Grievance and Appeals; Enrollment Operations) • 240 FTEs	• This team addresses telephonic and electronic inquiries, ensuring compliance with call performance metrics mandated by LDH, communicating education and plan materials for enrollees, as well as handling grievance and appeals, and enrollment functions. • Bachelor's degree; prior experience working in the health service industry and/or service operations; strong analytical skills; background in healthcare quality	
Provider Services (Contracting, Provider Data Management, Credentialing, Call Center, Provider Relations, Provider Engagement) • 262 FTEs	• This team builds relationships with providers through contractual agreements, facilitating education and training, escalating, and resolving issues on claims payment, supporting value-based payment arrangements, practice transformation, contract interpretation, and accuracy of provider information. • Bachelor's degree; three or more years of healthcare or managed care experience with Provider Contracting, Network Management, or Provider Relations; comprehensive knowledge of Medicaid policies, processes, and procedures	
Claims Payment Operations (Claims Processing/Payment	• Process team responsible for timely and accurate adjudication and payment of claims, including: code editing, and quality audit of claims; modify and document	**Claims Administrator and Encounter Data Quality Coordinator report to the**

Team and FTE Count	Roles, Operating Activities and Qualifications/Competencies	Team Lead and Reporting Lines
Processing, Code Editing, Financial Recovery (i.e. Payment Integrity) and Encounter Reporting) • 276 FTEs	processes to meet changing requirements, troubleshoot process problems; collect, oversee, and monitor timely and accurate transmission of data • Experience in healthcare claims processing, or combination of education, training and experience; Bachelor's degree or equivalent experience; experience with business process analysis, experience in healthcare industry or three or more years of managed care encounters experience	**COO**; these roles are targeted to be hired by readiness review.
Program Integrity • 8 FTEs	• This team identifies and investigates allegations of fraudulent and abusive practices, reports investigation results, and liaises with LDH and/or law enforcement on active investigations. • Bachelor's degree; minimum two years of healthcare fraud investigations and auditing experience; knowledge of healthcare payment methodologies and ability to analyze data; strong organizational, interpersonal skills, and ethics	[redacted]
Contract Compliance (Contract Management, Business Continuity, and Subcontractor Oversight, Regulatory Compliance and Risk Management) • 17 FTEs	• This team ensures that the plan, including our Material Subcontractors, remains aligned with the Model Contract and that appropriate contingencies are in place to continue operations in the event of an emergency, natural disaster, and other unexpected disruptions. Responsibilities also include oversight and submission of contract reporting requirements. • Bachelor's degree; experience in compliance and regulations for a health care programs	[redacted]
Finance and Accounting • 12 FTEs	• Team is responsible for measuring, monitoring, and reporting financial performance of the health plan and ensuring operations remain fiscally sound. This includes Actuary, General Accounting and Financial trend management and analytics. • Bachelor or Master in finance; three to five years of healthcare experience (managed care preferred)	[redacted]
Clerical and Support Staff • 10 FTEs	• Staff to support administrative functions of the health plan including Human Resources, Office Management, Marketing and Administrative Support • High school degree/equivalent; proficiency in Microsoft Office products; two years of experience in an office setting	**Administrative Assistants and other support staff report to the CEO and COO**; these positions will be in advance of the operational start date.

Scaling Staffing Levels Based on Enrollment

By creating ratios and modeling multiple enrollment levels using industry experience, capacity modeling, and LDH's Contract requirements, Humana's tailored staffing model aligns with enrollee needs and enrollment levels. With the support of remote associates, dedicated recruiters, and our Hudson and Veteran Initiative contractors, we can quickly place temporary and permanent associates to support enrollment increases. Starting with an existing roster of staff from our preparation for the 2019 RFP award, we will diligently work to fill any open positions for new and existing roles. Along with recruitment efforts, we anticipate quality referrals from our Louisiana-based associates, as well as candidates from any displaced incumbents, to fill open roles. **Our goal is to be fully staffed no fewer than 30 days prior to go-live (7/1/2022).**

2.6.2.2 Proposed Staff Qualifications and Organizational Structure

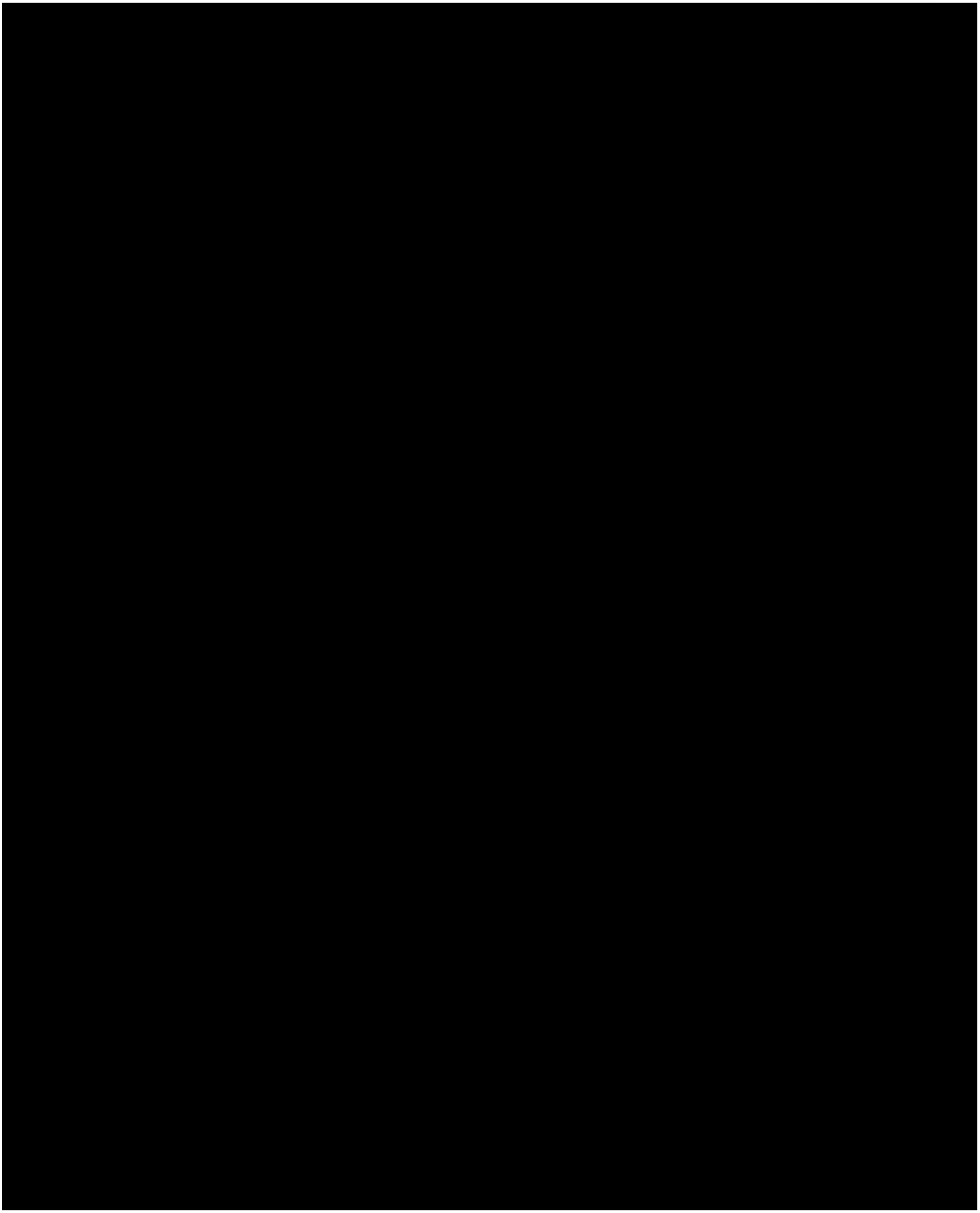
Attachment 2.6.2.2-1 Resumes
Attachment 2.6.2.2-2 Organizational Chart

[redacted]

[redacted]

[redacted]

[redacted]



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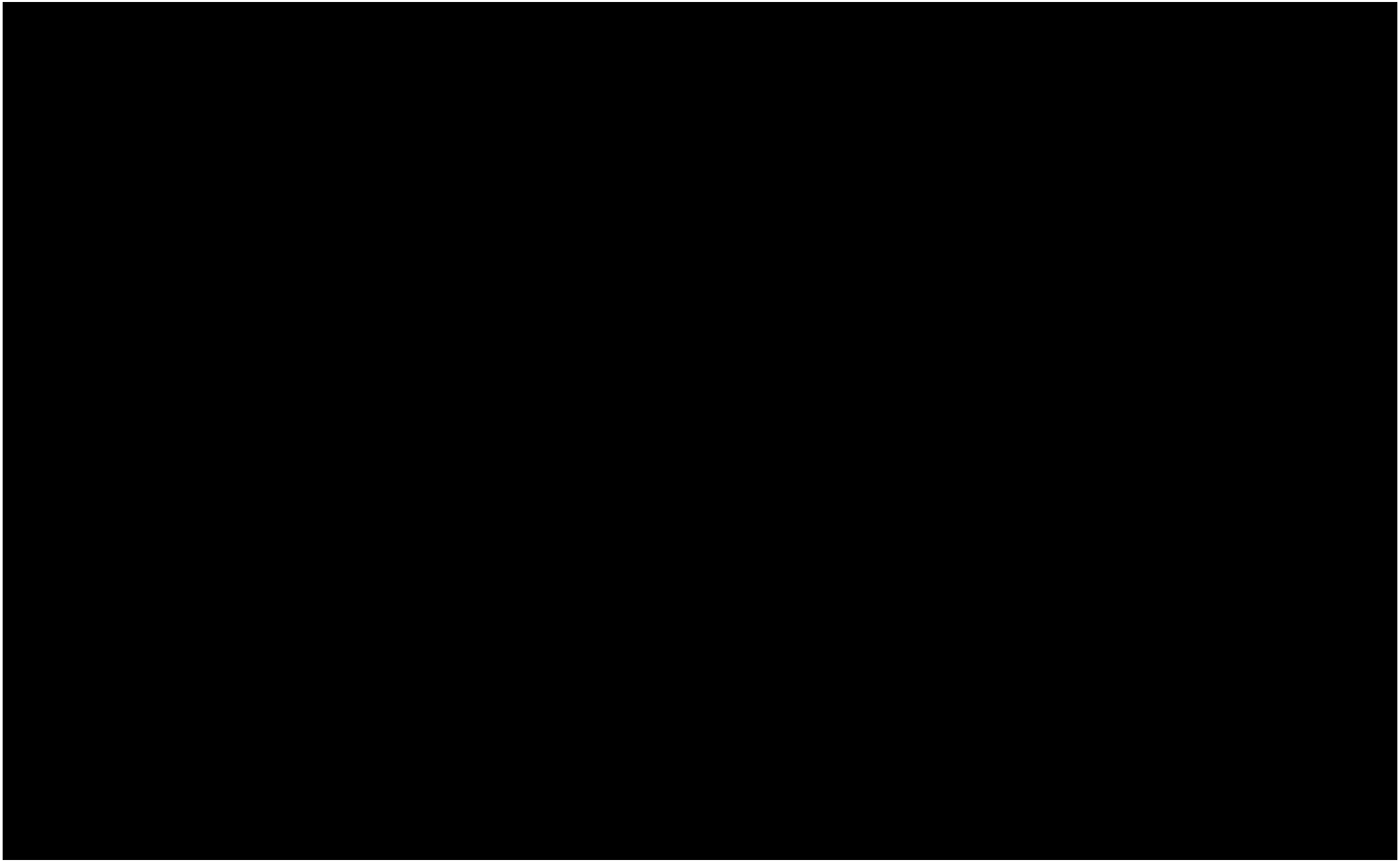

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Humana sponsored and participated in the 2021 Empowerment & Policy Conference, hosted by the Urban League of Louisiana via its Center for Policy and Social Justice, and The Louisiana Legislative Black Caucus.

Section 2.6.3

Enrollee Value-Added Benefits

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2.6.3 2.6.3 Enrollee Value-Added Benefits

[redacted]

2.6.3.1 Optional Value-Added Benefits for Enrollees

Humana Healthy Horizons in Louisiana will offer all eight optional VABs to our enrollees, which we will implement using our fully integrated **Empowered Care Plus (Empowered Care+)** care model. Our local leadership team developed our VABs using the lens of cultural competency and local health equity challenges in the parishes throughout Louisiana. Specifically, **we looked at individuals of racial, ethnic, and socioeconomic groups that experience health disparities and unjust disadvantages regarding health equity that can result in a lack of basic human needs**. These needs may include access to care, stable housing, access to a safe living environment, medical support, reliable transportation, a job they can depend upon to pay their bills, and a nearby location to find nutritious food to feed their families. [redacted] have established key relationships with leading community-based organizations (CBOs) throughout Louisiana that have been instrumental in developing benefits to serve the needs of our Medicaid enrollees.

Our local team traveled across the State to visit rural parishes and speak with providers, federally qualified health centers (FQHCs), Human Service Districts/Authorities (HSD/HSA), and community mental health centers to hear firsthand about the challenges they face. **For example, in Beauregard Parish we heard that local support primarily works through the faith-based institutions that know their residents and support them by addressing the challenges specific to their community.** The stories we heard and the lessons we learned helped inform development of the Empowered Care+ model for Louisiana, including the scope and features of our VABs to supplement this model.

Providing enrollees with simple, guided access to these benefits within their communities is one of many actions we are taking to improve their healthcare experience. We refer to this as human care, a concept deeply ingrained in Humana's company culture. We embrace this philosophy by guiding enrollees to the services that best meet their individual needs and training all enrollee-facing associates on the VAB details, including how to help enrollees access them within their local community. **No matter whom they contact, whether a Case Manager, a Community Health Worker (CHW), or an Enrollee Call Center associate, enrollees can access someone who can identify their needs and guide them toward their benefits.** As **Figure 2.6.3.1-1** shows, our Go365® incentive platform and smartphone app provide enrollees with rewards for completing healthy behaviors such as attending tobacco cessation or weight management counseling, well-child visits, prenatal/postpartum visits, health screenings, and receiving a flu or COVID-19 vaccination. Deeply rooted in behavioral economics, Go365 supports and encourages all enrollees to live healthier while reducing healthcare costs.

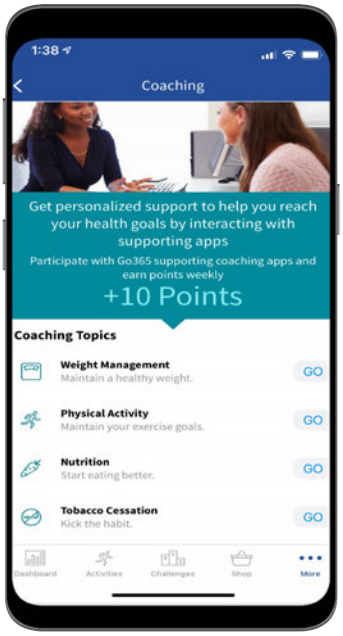


Figure 2.6.3.1-1: Go365

2.6.3.2 Additional Value-Added Benefits

[redacted]

[redacted]

[redacted]

We have aligned the detection and treatment support of our Opioid Use Disorder (OUD) Program with recommendations from the HOPE Council, the Opioid Surveillance Program, and the Comprehensive Opioid Abuse Program (COAP) Action Plan.

[redacted]

[redacted]

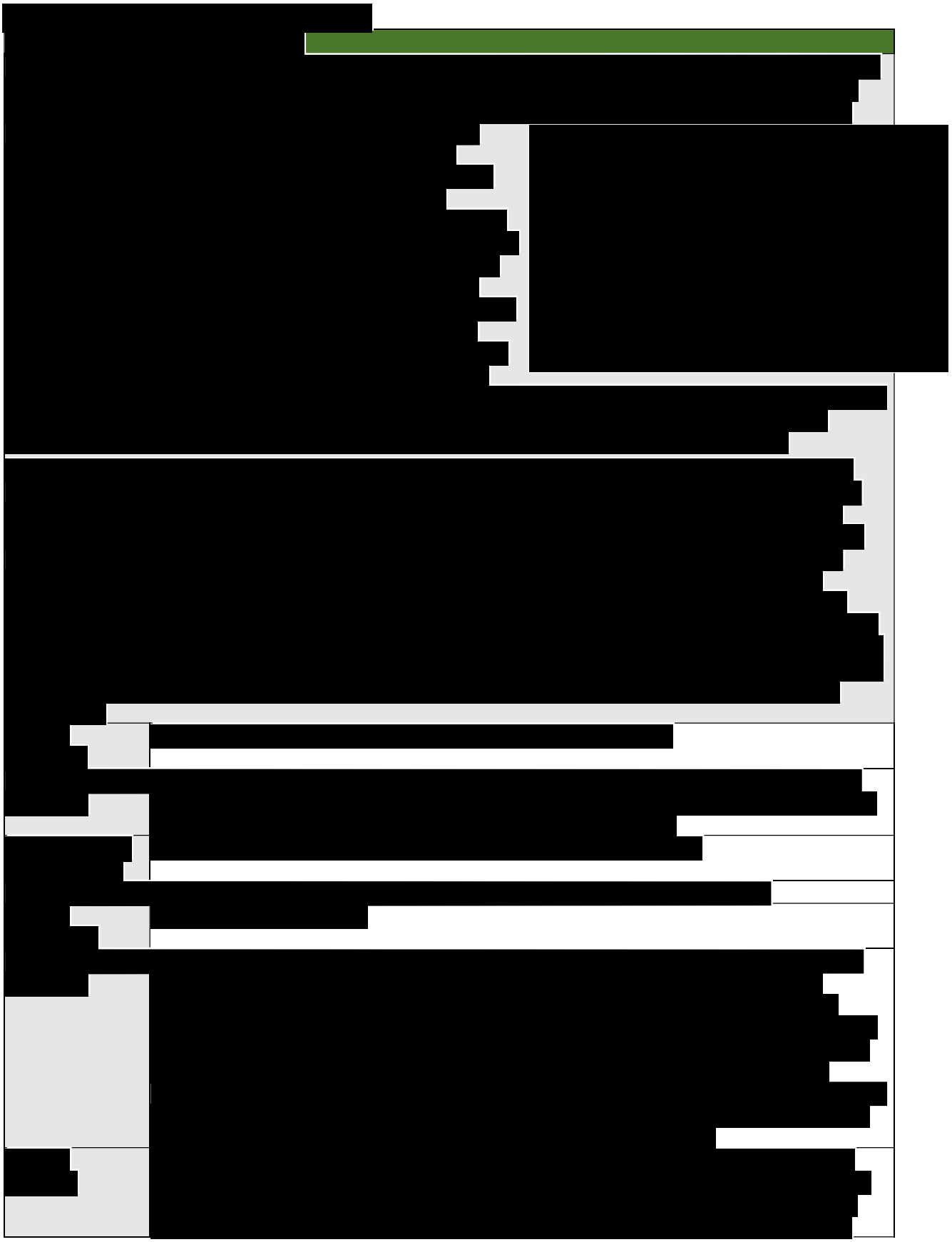
[redacted]

treatment. **We connect the enrollee to local**

[redacted]

[redacted]

[redacted]



[redacted]

[redacted]

[redacted]

Coordinating with Louisiana Asthma Programs: Education and Health Equity

Humana will coordinate with local organizations such as Louisiana's Asthma Management and Prevention Program supported by CDC to educate and support our enrollees with asthma. This program helps educate school personnel on asthma and prevention, identifies children who require asthma action plans, and develops indoor and outdoor clean air policies for asthma-friendly school districts. As part of our education efforts, we will inform enrollees about registering for the program's help-line to learn more about asthma and managing their condition. We will also refer enrollees to the BREATHE program (Bringing Respiratory Equity for Asthmatics Through Healthier Environments) developed by the Green & Healthy Homes Initiative (GHHI) in collaboration with the LDH Environmental Public Health Tracking Program and the Louisiana Center for Health Equity. The BREATHE program partners with Our Lady of the Lake Children's Hospital to provide virtual home visits to clients with poorly controlled asthma or health-harming environmental concerns.

[redacted]

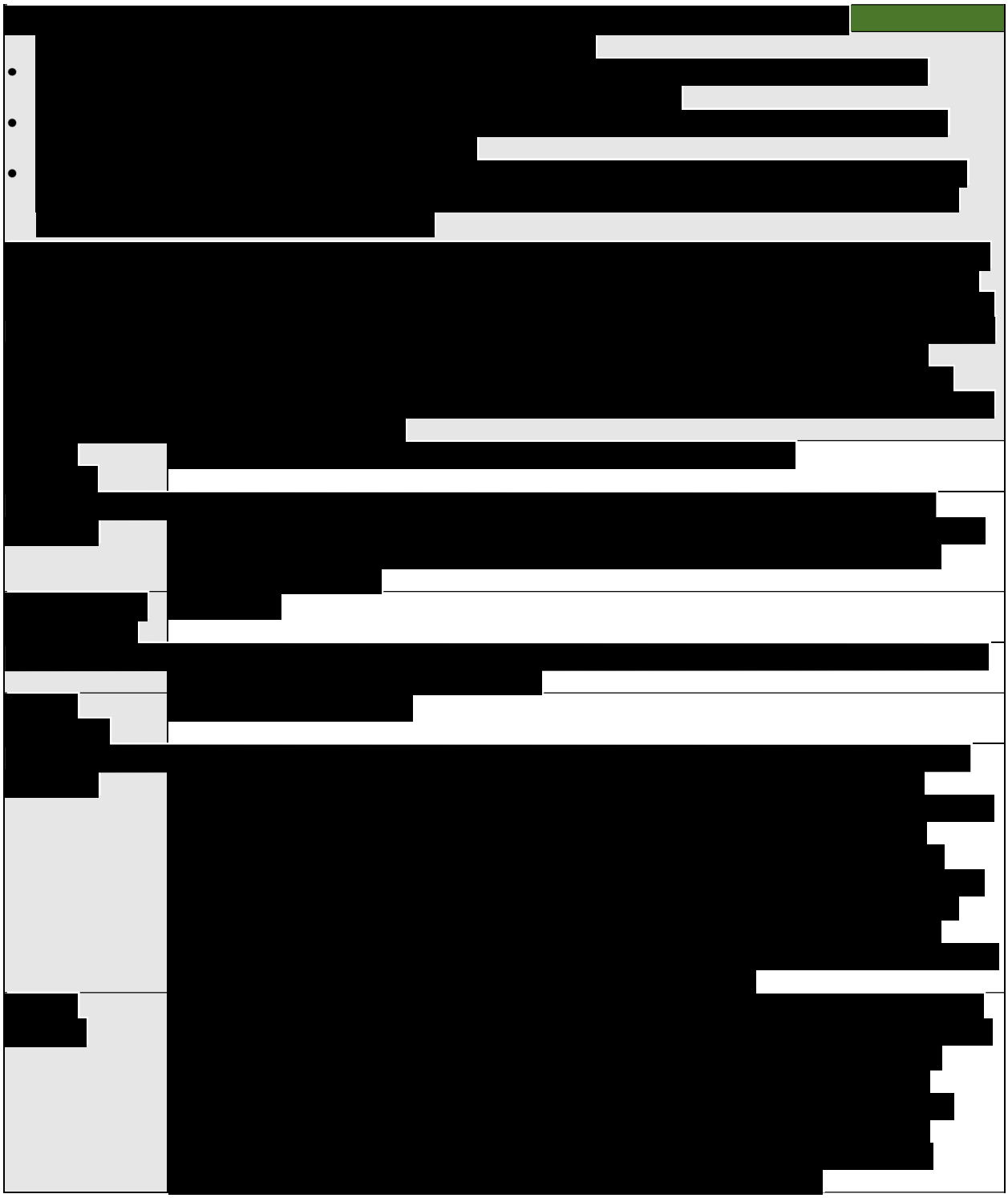


Table 2.6.3.4-1: PMPM Actuarial Value

[redacted]

Actuarial Statement

I attest that I meet all of the requirements under the American Academy of Actuaries US Qualification Standards and am qualified to certify the estimated value for the VAB enclosed with this Request for Proposal (RFP). Based on my qualifications and my understanding of the Centers for Medicare & Medicaid Services (CMS) and LDH requirements, I have prepared the valuation and certify that to my best knowledge, information, and belief, all statements made by Humana with respect to the pricing of VAB in the enclosed RFP are complete, accurate, and truthful, and follow CMS and LDH instructions.

- Experience data was prepared by the Medicaid Actuarial Pricing team. I relied on experience data collected from other Humana Medicaid programs as well as market insights gained from the review of the RFP to make the assumptions needed to provide the best possible pricing estimate for the VAB.
- Certain assumptions, including utilization assumptions, capitation rates, and other cost assumptions were provided by individuals from the Product Design and Development team. I relied on those individuals' experience in product development and have reviewed the assumptions for reasonableness.

[redacted]

a. Normalized experience from Humana's other Medicaid programs

7. Nonclinical Home-Based Asthma Interventions
   a. Normalized experience from Humana's other Medicaid programs
8. Home Visiting Programs for Pregnant and Postpartum Enrollees and their Newborns
   a. Normalized experience from Humana's other Medicaid programs

All pricing assumptions were reviewed by other members of the Medicaid Actuarial Pricing team as well as others from Product Development and Medicaid Finance.

Rodger Yan
Certifying Actuary's Signature

Humana Value Added Benefits
Louisiana Medicaid Managed Care 2021 RFP

August 16, 2021

2.6.3.5 Statement of Commitment to Provide Benefits for Entirety of Contract Term

Humana Healthy Horizons in Louisiana commits to provide the selected value-added benefits for the entire 36-month term of the initial Contract and for any extensions, if applicable.

Kingsley House Senior program allows seniors to engage in gardening activities. Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

Section 2.6.4

Population Health

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2.6.4 2.6.4 Population Health

Humana Healthy Horizons in Louisiana has reviewed and confirms adherence to the LDH expectations and requirements in **Model Contract Section 2.5 Population Health and Social Determinants of Health, and MCO Manual Part 6: Population Health and Social Determinants of Health**.

2.6.4.1 Approach and Experience Improving Population Health

Population health is a foundational element of Humana's enterprise mission and a core component of our managed care programs. We define population health as the outcomes of enrollees and the communities in which they reside, including the distribution of such outcomes within the group. Through our whole-person health model, we address the three key facets of population health within a community: physical, behavioral, and social. Using a data driven approach, we assess enrollees' needs, improve their health and well-being through interventions for key subpopulations, and continuously measure and monitor outcomes. Our 36-year presence in the State serving over 450,000 Medicare Advantage (MA), Dual Eligible Special Needs Plans (D-SNP), Medicare Part D Prescription Drug Plan (PDP), and commercial enrollees, as well as TRICARE beneficiaries across all 64 Louisiana parishes, ideally positions us to expand our relationships with stakeholders, communities, and providers to address LDH's population health priorities. We operate 42 NCQA-accredited health plans across our Medicaid, commercial, and MA lines of business, **leading all national MA plans with 92% of our MA HMO and more than 99% of Group MA beneficiaries enrolled in 4.0-Star plans or higher in 2020. For three consecutive years, our Florida CarePlus MA HMO plan achieved a 5-Star rating**.

Impacting social determinants of health (SDOH) and well-being has been core to Humana since our founding. Our focused enterprise-wide population health strategy, Bold Goal, began in 2015 with our commitment to develop programs and partnerships to improve the health and well-being of the people and communities we serve by making it easier for everyone to achieve their best health. This journey began with seven pilot communities nationally, and **because of Humana's deep roots in Louisiana, Baton Rouge and New Orleans were two of the original and longest tenured communities**. These pilots and our deep relationships with providers, nonprofits, and business and government leaders in both cities became the baseline for our growth into other markets. We forged working relationships with community-based organizations (CBOs) to co-create solutions to address some of today's most complex health and social problems. We focus on implementing culturally competent initiatives to address SDOH needs**, with a lens of health equity,** to significantly impact population health.

Bold Goal New Orleans and Baton Rouge: Bold Goal, one of our key population health strategies, measures health status via the CDC Health-Related-Quality-of-Life (HRQoL) tool, Healthy Days, and SDOH screenings that reveal social needs barriers to health and quality of life. In 2019, the community-wide coalition completed its Community Health Improvement Plan and proceeded with implementation, working toward a healthier Baton Rouge for all residents. **In 2020, our Bold Goal MA members experienced only 12.64 unhealthy days in New Orleans, and 13.03 in Baton Rouge**. Bold Goal 2020 included integrated care delivery with the Baton Rouge Clinic; the "Yes we can" COVID-19 campaign loneliness pilot, Papa Pals; Mom's Meals; and SDOH value-based care innovations with Ochsner Health. **Our Humana Baton Rouge members have benefited from year-over-year reductions in unhealthy days for four years**, demonstrating how strong community leadership and a locally led coalition can provide a solid foundation for improving health. 2020 also saw increased collaboration with **New Orleans** providers to identify and integrate SDOH into clinical settings; we also partnered with the New Orleans Health Department and community stakeholders to form a Community Health Improvement Plan. These partnerships were essential to rapidly deploy resources when COVID-19 restrictions caused food insecurity and social isolation and exacerbated SDOH issues in 2020. Likewise, our active collaboration with providers and community stakeholders helped Healthy Baton Rouge support the city during the 2020 pandemic.

Improving population health remains at the center of our approach to serving enrollees and communities. We employ a holistic approach, incorporating physical and behavioral health (BH), and social and environmental factors, such as disaster preparedness, into our clinical interventions to advance health equity and outcomes. To ensure that population health is at the forefront of our

operations, our [redacted] Senior Vice President and Chief Health Equity Officer, Nwando Olayiwola, M.D., MPH, FAAFP; Vice President, Medicaid Population Health, Ian Nathanson, M.D.; and enterprise Vice President of Population Health Andrew Renda, M.D. MPH, will provide national support for our Louisiana team.

Humana's Population Health Approach

Humana recognizes the roles population health, healthcare quality, and health equity play in in creating a connected ecosystem that achieves optimal health for our enrollees and communities. Our approach unites community partnerships and stakeholders in the healthcare ecosystem with population identification, data integration stratification, intervention, and measurement. We leverage local Robert Wood Johnson Foundation data and Louisiana's subpopulation data to identify opportunities to **address LDH's key, prevailing health concerns**: Communicable diseases, such as HIV, hepatitis C virus (HCV), and sexually transmitted infections; maternal mortality and morbidity and neonatal abstinence syndrome (NAS); mental illness; diabetes mellitus, hypertension, cardiovascular disease, cancer screenings, and tobacco cessation; and early childhood health and development, including Adverse Childhood Experiences (ACEs). [redacted] Humana employs sophisticated population health data analytics to understand population challenges, stratify and prioritize unique subpopulations' needs, and evaluate the impact and outcomes post-intervention.

Addressing Population-Level Physical Health, Behavioral Health, and SDOH Areas for Improvement

In 2018, CDC stated Louisiana ranks 47th nationally in the incidence of diabetes and obesity, and 49th in maternal mortality. Within Louisiana, Baton Rouge had the highest rate of HIV in the country; New Orleans ranked third. We promote collaboration among health plans, local officials, and CBOs to address these and other population-level health, and health-related challenges via enrollee data stratification, interventions, and outcomes assessment. Measuring our progress using CDC's HRQoL measures, including Healthy Days, we focus on prevention, community-wide health, and access to quality care. We incorporate continuous quality improvement across cohort creation, enrollee engagement, intervention

development, and data evaluation and reporting. We include data from **Model Contract Section 2.5.1.2** and LDH's Health Needs Assessment (HNA) results into our population health cohort development, and Robert Wood Johnson Foundation data in our community health dashboards. Humana tailors enrollee engagement to address unmet needs, promote and incentivize healthy behaviors and disease self-management, and develop robust Case Management (CM) programs for individuals with special healthcare needs (SHCN). In partnership with providers, CBOs, and public agencies, we implement campaigns, educational materials, and interventions. We also leverage LDH-mandated measures, the Triple Aim Population Health Dashboard, and enrollee outcomes to implement CQI processes using the HRQoL metric, Healthy Days, and multiple clinical and quality measures. [redacted]

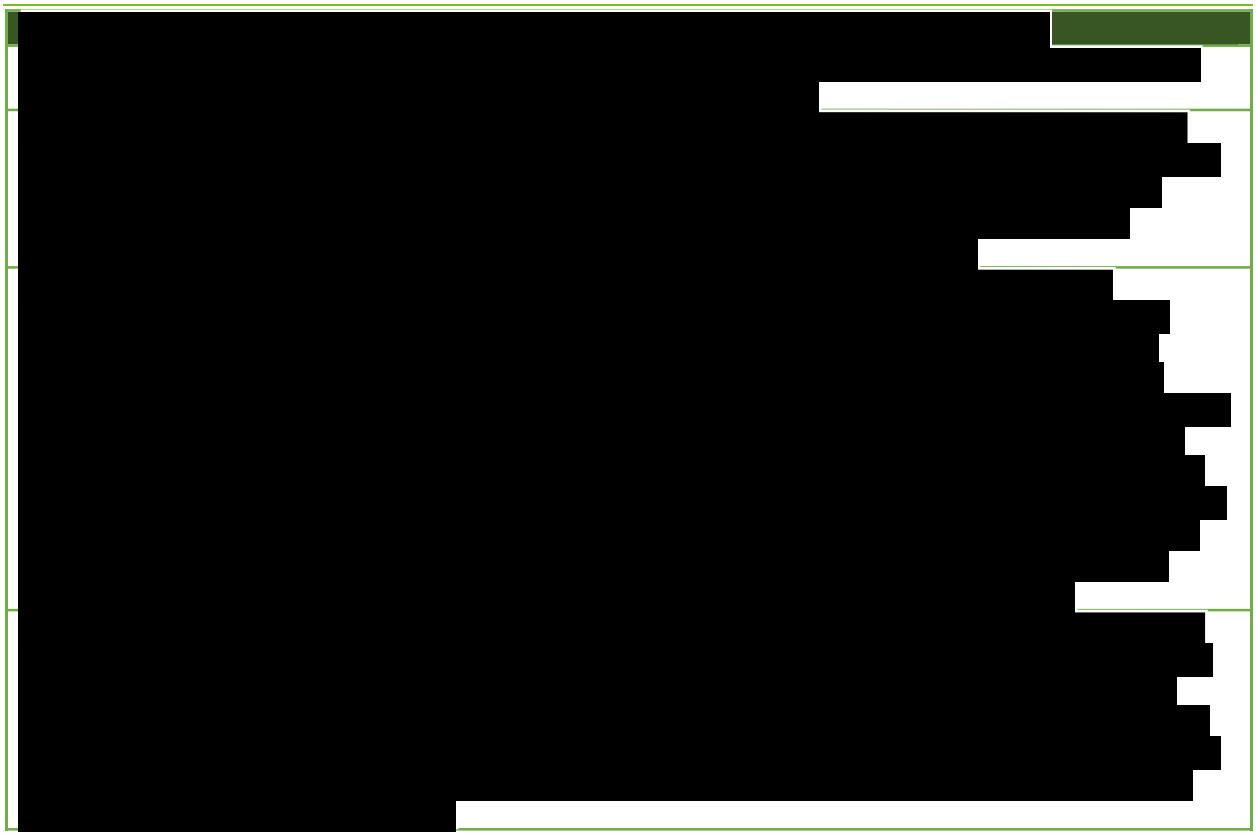
Humana's Population Health Strategic Plan

Aligned with the Louisiana Medicaid Managed Care Quality Strategy, our Population Health Strategic Plan combines enterprise-wide health equity with an innovative and cost-effective healthcare delivery system to support LDH's population health and quality strategy goals. Our Population Health Strategic Plan ensures access to care and improves coordination and transition of care to meet all enrollee needs. The plan also facilitates patient-centered, whole-person health, incorporating physical and behavioral health, and SDOH/health-related social needs, all while promoting wellness and prevention. Our plan outlines our partnerships with CBOs to improve population health and address health disparities, implement pay-for-value and innovation incentives that encourage chronic disease self-management and control, and minimize wasteful spending. Our Population Health Strategic Plan also incorporates the employment of local community health workers (CHWs), strong CBO relationships, and the integration of cultural competency priorities into our person-centered approach to inform improvements in care delivery. We incorporate health equity principles and processes as we address enrollee communities' critical SDOH and care gaps, aligning our strategic relationships with local coalitions, State agencies, and network providers to create evidence-based and financially sustainable population health solutions. We solicit **Enrollee Advisory Council feedback in our root cause analyses** to understand local and personal experience as well as environmental context affecting prioritized issues. This information, along with responses from the communities we serve, informs the population health modifications we make to better serve our Medicaid enrollees. For example, **we sponsored and participated in the 2021 Empowerment & Policy Conference, hosted by the Urban League of Louisiana via its Center for Policy and Social Justice and The Louisiana Legislative Black Caucus**. These conversations covered the breadth of education equity, health equity, voter education and engagement, criminal justice reform, and workforce and economic development to shape 2021 policy priorities. We will continue hosting "Listening Sessions" and engaging residents at our **Baton Rouge, Lafayette, Lake Charles, Metairie, and Shreveport Neighborhood Wellness Centers, or other community locations, to effectively serve both rural and urban populations.**

Experience Improving Population Health for Similar Louisiana Populations

With nine local Louisiana offices, two Bold Goal communities, and over 1,200 volunteer hours in the first two quarters of 2021, we have demonstrated our commitment to improving population health for more than 450,000 enrollees across our lines of business. Humana has been a thought leader in Louisiana for more than seven years, leading and working in local communities to drive solutions to SDOH and priority health initiatives. We will apply that experience to improve population health for Louisiana's Medicaid population, as shown by our most recent experience summarized in **Table 2.6.4.1-1.**

[redacted]

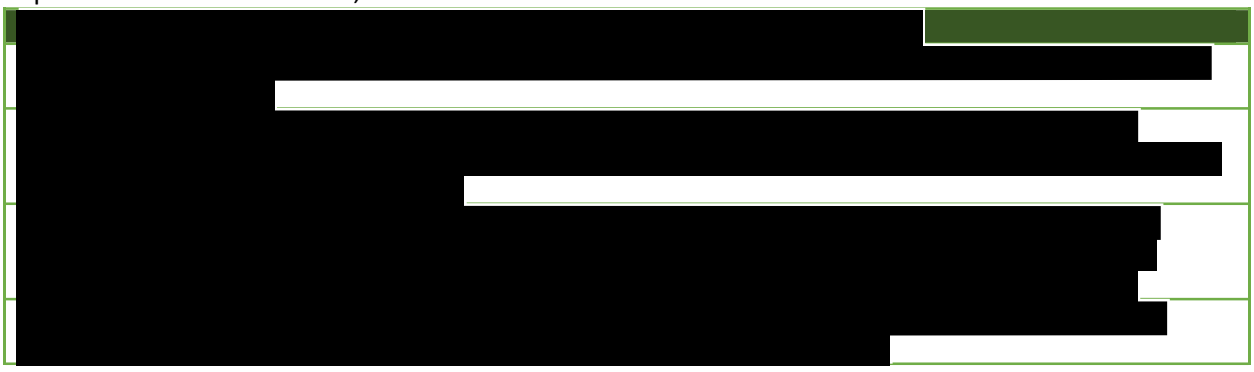


Our Population Health Approach Principles Inform and Guide Our Managed Care Program

Founded on health equity, our population health principles inform and guide our managed care program, driving innovations that produce measurable, improved outcomes and reduce avoidable healthcare costs across the entire enrollee population. Our person-centered, outcome-driven care model addresses enrollees' physical, BH, and SDOH needs via strong relationships with providers, CBOs, business, and government leaders. These principles enable us to co-create solutions that address the complex health and social challenges that impact the entire community.

2.6.4.1.1 Identifying Baseline Health Outcome Measures

Our model addresses enrollees' health needs at all points along the care continuum. Therefore, we set health outcomes measures and targets for priority conditions across four domains: Maintaining enrollee health, managing individuals with emerging risks, patient safety, or outcomes across settings, and managing multiple chronic illnesses. We use an array of data sources, including HEDIS® and non-HEDIS goals in **RFP Attachment H Quality Performance Measures**, to establish baselines and targets for health improvement for each metric, shown in **Table 2.6.4.1-2**.



[redacted]

We proactively collect enrollee health and SDOH data via welcome calls, HNAs, Healthy Days telephonic surveys, and post-discharge calls to build on enrollee baseline data. [redacted] Capturing data in a centralized ecosystem, we establish baselines, using tracking tools and dashboards for regular reporting and apply advanced analytic capabilities to create enrollee segmentation and predictive models, and to also predict and prevent future events and disease progression. Our population health strategy includes **primary prevention** — intervention before health effects occur, such as tobacco cessation, COVID-19 and flu vaccinations/immunization rates, maternal health, and SDOH prevalence; **secondary prevention** — screening at early stages of diseases including colorectal/cervical cancer, diabetes, HIV, HCV, and COVID-19; and **tertiary prevention** — managing disease post-diagnosis to slow/stop disease progression, including HIV viral load suppression, HCV antiviral treatment, and diabetes A1c and hypertension control.

[redacted]

We will partner with LDH (and other State agencies), other MCOs, and key stakeholders to identify outcome measures and goals for health improvement, using an agile approach to scale and increase our efforts during times of significant need. [redacted]

[redacted]

2.6.4.1.2 Measuring Population Health Status and Identifying Subpopulations

In accordance with **Model Contract Section 2.5.1**, Humana's Population Health Strategic Plan will include a strategy for measuring population health status and outcomes and identifying subpopulations. We **measure population health status** by incorporating State and public data into our data analytics solutions.

[redacted]

s.

Humana harnesses data to build operational dashboards to track population health metrics and follow trends over time, drill down to specific segments, and closely monitor subpopulation outcomes. Our

Market Health Scorecard, Community Health Dashboard, and Root Cause Analysis (RCA) tools synthesize these metrics to identify characteristics and needs of the population. The Market Health Scorecard reviews more than 100 key health, clinical, claims data, and business performance metrics to assess overall community health and identify opportunities for improvement. This tool provides a highly interactive data visualization of Medicare, Medicaid, and commercial populations; filtered by market, provider group, and condition to identify Healthy Days key performance indicators, and align initiatives. The **Community Health Dashboard** delivers population trends, insights, and benchmarks, using Robert Wood Johnson Foundation County Health Rankings and claims data, to identify pilot communities and population health strategies. **Our RCA integrates Enrollee Advisory Council and Provider Advisory Council feedback to understand the dynamics that may contribute to health disparities**.

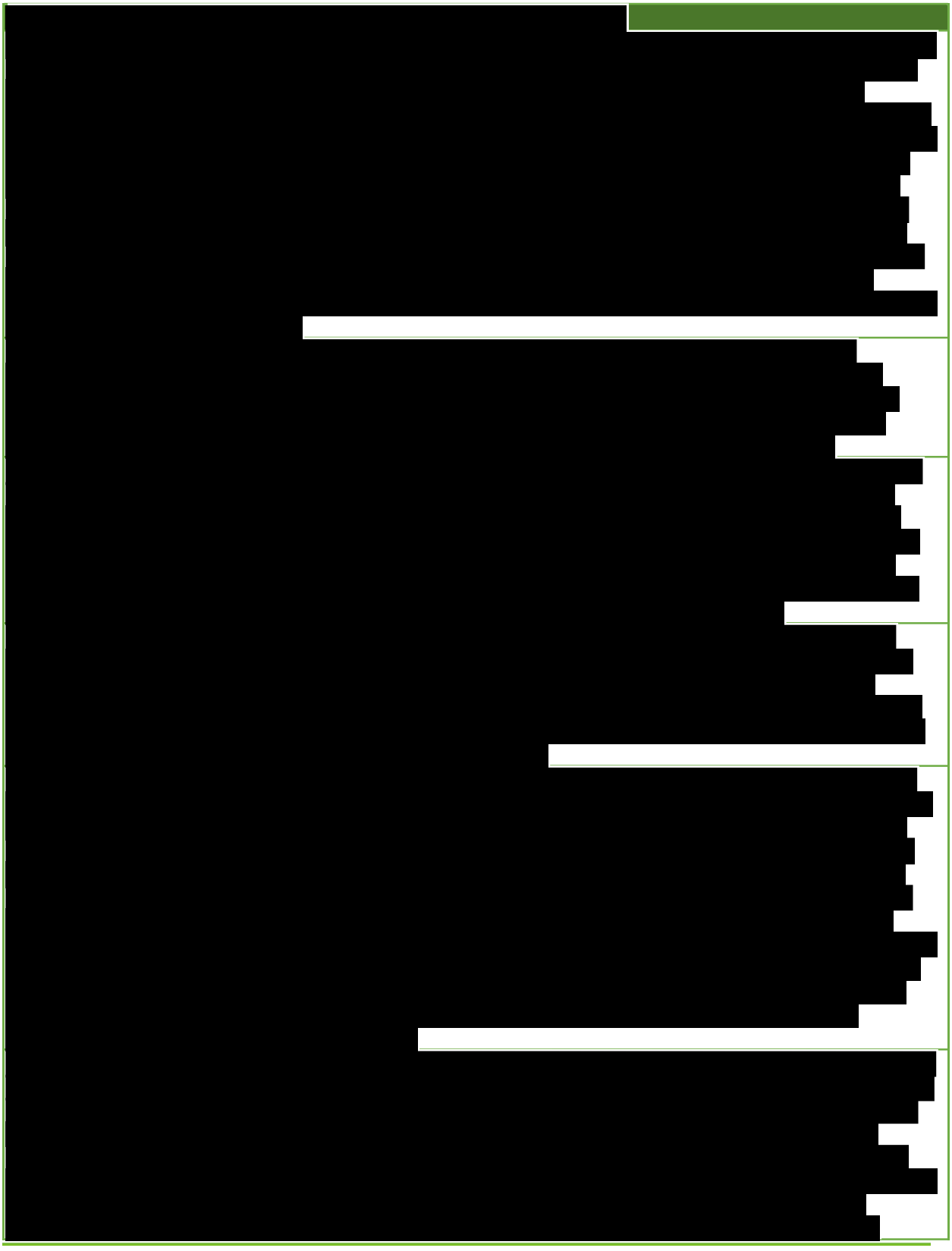
Identification of Subpopulations

Beyond provider and enrollee self-referrals, we use a **proven three-step approach** to identify subpopulations experiencing disparate levels of SDOH needs, demonstrate unequal levels of poor health outcomes, or encounter access issues based on factors such as [redacted]

2.6.4.1.3 Identifying Key Determinants and Strategies to Reduce Disparities

Humana prioritizes improving the entire population's health status through prevention, identifying subpopulations with complex needs, and implementing strategies to reduce health inequities. We regularly incorporate external public data sets into our models to identify population-wide trends and determine how they apply to our enrollees. [redacted]

care, which helps us create personal and connected experiences for enrollees and their families as they make educated decisions and navigate the healthcare system. Our 360-degree view of enrollees uses targeted interventions, outlined in [redacted]



[redacted]

2.6.4.1.4 Integrating Procurement Requirements and our Initiatives into Population Health

In compliance with **Model Contract section 2.5.1**, **our** [redacted] As a voting member of our Quality Assessment Performance Improvement (QAPI) committee, she will help our Louisiana leadership team, address population health initiatives and overall strategy. In alignment with the Model Contract, we will deploy local CHWs as part of our CM staff across the State, providing critical feet-on-the-street assistance with locating, engaging, and coordinating enrollees' physical health, BH, and SDOH services, while working in alignment with our provider community, Case Managers, and CBOs. Our SDOH Coordinators support enrollees and CM staff throughout Louisiana, maintaining local CBO relationships to ensure access to needed services. [redacted] will work together to ensure the highest degree of integration between Humana's clinical programs and the plan-wide initiatives and partnerships, including developing a mechanism for regular feedback and information-sharing with our SDOH Coordinators to link local efforts with Statewide priorities.

Empowering Providers to Advance Population Health

Humana Healthy Horizons in Louisiana's Provider Engagement Model (PEM) drives our Medicaid provider support strategy and promotes administrative simplicity a single point of contact. Our PEM, supported by regionally dispersed, Medicaid staff, ensures timely claims processing and payment and **improves provider quality and performance** using a comprehensive suite of data analytics tools. It supports integrated care through tailored provider education, enabling providers to advance along the value-based care continuum and our **Valued Care Plus (Valued Care+)** value-based payment models. We offer participating providers a monetary incentive for each Humana enrollee's completed Notification of Pregnancy form to engage pregnant enrollees more quickly in our Moms First program. We incentivize enrollee assessment for SDOH needs, including food insecurity, using the Hunger Vital Sign™ two-question screening tool. We provide training and tools to screen for food insecurity and discuss its health impacts with affected enrollees. We educate and empower providers to connect their patients to clinic and community resources. For example, in 2019 through our Bold Goal forum, we increased provider collaboration to integrate SDOH into the clinical setting. We engaged with the New Orleans Health Department and community stakeholders to form a Community Health Improvement Plan. When social support needs increased in 2020, we set an enterprise-wide goal to conduct three million Bold Goal screenings; we completed 6.2 million social needs screenings. Our enrollees had 816,000 more Healthy Days, with a 6.8% decrease in unhealthy days from the 2015 baseline year. Compared to Medicare fee-for-service, we achieved a **21.5% cost savings, driven by a 27.5% drop in inpatient admissions and a 2.5% reduction** in ED visits in 2019. Our value-based payment providers are more successful at completing Medicare enrollees' primary and preventive care visits, with 87.5% assigned enrollees receiving a preventive care visit in 2020. By hiring local Case Managers and CHWs and using the Humana care gap data, our full-risk providers can address the SDOH that affect enrollees' outcomes.

2.6.4.1.5 Other Considerations on Our Approach to Improving Population Health

We are committed to collaborating with other payers, CBOs, and providers to implement innovative population health initiatives. We select community partners and develop innovative pilots using careful analysis to identify the issues we can impact, such as the following proposed pilots and initiatives shown in **Table 2.6.4.1-7**.

2.6.4.2 Addressing Population Health in the First Year of the Contract

We will submit our Population Health Strategic Plan to LDH at Readiness Review, and annually thereafter, per **Model Contract Section 2.5.1**. In addition to the Contract requirements and milestones addressed in Year One illustrated in **Table 2.6.4.2-1,** we continue to support **New Orleans Mayor LaToya Cantrell's 2019 Generational Gun Violence Reduction Plan** to reduce gun-related deaths over the next 50 years**.** Since 1986, New Orleans has been one of the top five deadliest cities in the U.S. While 2019 was one of the city's most peaceful years, deaths increased by more than 60% in 2020. We know that creating employment opportunities improves health outcomes, reduces gun violence, and reduces costs to private corporations and governments. **In partnership with the City of New Orleans,** we are providing thought leadership, predictive modeling, and analytic tools to support employment-related interventions: **CEO Works** provides transitional employment reducing blight and cutting grass, for citizens returning from incarceration, and offers soft skills training, resume building, and professional development. **Opportunity Youth Jobs** connects youth who have disconnected from work and school with an eight-week soft-skills training program and employment opportunities through the City's Office of Workforce Development and Federal Department of Labor. **Regular Summer Jobs Program,** through the City's Recreation Department and the Office of Workforce Development, provides nearly 1,200 jobs for young people over five weeks each summer. **Pathways Program,** the Mayor's Office of Youth and Families 15-week internship program, pairs previously arrested youth with minority-owned businesses across New Orleans. **Cognitive Behavioral Therapy and Haircuts** offers free haircuts paired with cognitive behavioral therapy and employment opportunities to persons at increased risk of violence. Research suggests this is one of the most promising interventions for preventing violence.

> “Humana is a valued managed care partner in the development of innovative population health programs that directly address our key behavioral health and social determinants of health challenges. We are excited to work together to reduce gun violence by innovatively funding upstream, evidence-based interventions for the citizens of New Orleans. This collaboration has the ability to drive health system reform while delivering positive health outcomes for our community.”
> – Mayor LaToya Cantrell, City of New Orleans

2.6.4.3 Experience Using Data Regarding SDOH to Improve Health Equity

Our experience using SDOH data to improve population health outcomes and health equity in our Louisiana MA and other Medicaid contracts prepares us to address population health issues. The following examples in **Table 2.6.4.3** show how we identified an issue, the interventions we developed, how we assessed the interventions' impacts, and what outcomes we achieved. We have highlighted how we can apply this approach to population health and/or health equity priorities named in the Model Contract.

[redacted]

2.6.4.4 Humana's Approach to Engage Providers, Enrollees, and Families

Humana has a demonstrated history of engaging enrollees, and collaborating with CBOs and providers to improve health equity without replicating or duplicating services as shown in **Table 2.6.4.4**.

Table 2.6.4.4: Engaging Enrollees, Families, and Providers
Engaging Enrollees and Families: We work to understand enrollee needs and challenges, and meet them where they are. The 2019 Statewide Listening and Learning Tour engaged more than 250 community members from Alexandria, Baton Rouge, Shreveport, Monroe, Lafayette, Lake Charles, and New Orleans. It included interviews and focus groups with BH providers to assess regional needs. With Humana's support, the 2021 tour will be an opportunity for intimate, honest dialogue regarding issues affecting Black communities across the State to improve access to care, reduce health inequities, and improve overall health outcomes. We request frequent feedback via satisfaction surveys, Enrollee Advisory Councils, and through enrollee contact, which we incorporate into our overall population health/health equity approach to respond to enrollees' needs. We will also leverage EHR and HIE data to identify gaps in care for the enrollee population. To confirm we meet healthcare and SDOH needs, and resolve health equity concerns, our CM teams use motivational interviewing to engage enrollees and their families in person-centered care planning.
Engaging CBOs and OPH to Coordinate Population Health and Increase Health Equity: [redacted] oversee our CBO contracts and our OPH relationship to coordinate population health-improvement strategies to increase health equity. As a Louisiana native with vast knowledge of the State and years of experience serving the local population, she is aware of the enrollee-health equity issues to target. To engage providers, our **Valued Care+** models include incentives to address care gaps and health equity issues and encourage SDOH screening and referrals.
Engaging Providers to Improve Health Equity: Providers who screen for SDOH may be eligible to receive additional payment incentives when a provider makes an SDOH referral to enrollees with identified needs and documents closure of the referral. Our Provider Relations staff will work with network providers to tailor training to each parish's disparities (e.g., provider trainings on institutional racism and how to address racial bias and unconscious bias), particularly those in parishes with high rates of Black infant and maternal mortality such as Caddo and Orleans Parishes. Recognizing the shortage of providers willing to serve under-resourced communities and the extra costs they incur, some states have adopted programs and more equitable provider payment mechanisms, as Louisiana has done with their Health Professional Shortage Area incentive program, to encourage providers to serve these communities and support those who do. We will assess the provider's readiness for our **Valued Care+** value-based payment models and informational resources to support provider-led SDOH screening and referrals.

Kingsley House Head Start program: Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

Section 2.6.5

Health Equity

Humana

Healthy Horizons™
in Louisiana

2.6.5 2.6.5 Health Equity

Humana Healthy Horizons in Louisiana confirms adherence to **Model Contract Section 2.6**.

2.6.5.1 Management Techniques, Policies, Procedures, and Initiatives

Management Techniques: Humana integrates health equity into all aspects of our operations and it is a foundation of our approach. **Humana's Senior Vice President and Chief Health Equity Officer, Nwando Olayiwola, M.D., MPH, FAAFP,** works with leaders across the enterprise to ensure we fully integrate cultural sensitivity and racial empathy into the design of our programs, products, and services, while we collaborate with the broader healthcare community [redacted]. As part of our commitment, **Humana will pursue the National Committee for Quality Assurance (NCQA) Health Equity Accreditation Plus** (transition from the Distinction in Multicultural Health Care, effective July 2022) for our Louisiana plan and incorporate this goal into our **Louisiana Health Equity Plan**.

Policies and Procedures: **Humana embeds health equity into all its policies and procedures (P&Ps).** Humana Healthy Horizons' Culturally and Linguistically Appropriate Services (CLAS) Program guides our data-driven, comprehensive approach to reduce health disparities. **The program is governed by our governing CLAS Program Description P&P, implemented through an annual CLAS Work Plan, and assessed by an annual CLAS Program Evaluation**. As part of this process, our Quality Leadership teams review stratified data sets, including quality metrics, provider network cultural responsiveness analyses, and satisfaction measures, to pinpoint root causes of disparities and prioritize areas for intervention. We engage enrollees and community stakeholders to gain first-hand, highly localized information to inform our understanding of their needs. Under the direction of our [redacted] departments use this information to launch targeted initiatives. This systematic structure enables us to take a proactive approach to identify disparities and employ data-driven initiatives to achieve measurable reductions in the health inequities.

Initiatives to Promote Health Equity: Our experience addressing the long history of racial inequity and health disparities has informed our approach and commitment to closing the disparity gap. In 2020 we enhanced our **Humana Hometown Support model** in response to increased community focus on racial equity and health disparities. Humana **donated $11.5 million and 160,000 associate volunteer hours focused on rebuilding, relief, equity, and inclusion efforts in Louisville**. Our lessons learned and best practices have shaped our highly localized, data-driven, national approach, depicted in **Figure 2.6.5.1-1, which we will bring to Louisiana**.

Figure 2.6.5.1-1: Humana's Multi-Pronged Approach to Addressing Health Disparities

Approach for Louisiana: Our dynamic approach prioritizes a full understanding of our Louisiana Medicaid membership, augmenting our robust data collection processes through our Louisiana-based associates and direct engagement with enrollees, providers, and community organizations. To date, **we have engaged with over 100 stakeholders across**

every region of the State as part of our Health Equity Listening Tour to learn about regional challenges and nuances faced by the state's diverse populations. These insights have shaped our enrollee engagement approach for Louisiana and enables us to be fully prepared to effect change upon Contract award. Recognizing that significant strides require system-wide change, **Humana will seek collaboration with the Louisiana Department of Health's (LDH) Office of Community Partnerships and Health Equity, the LDH Office of Public Health, other selected managed care organizations, and community partners to convene a workgroup to examine disparities and identify interventions to drive systemic change.**

Humana Awards & Recognitions

For the fourth consecutive year, Diversity, Inc. named Humana to their **Top 50 Companies for Diversity**, ranked 13th in 2021.

In 2021, the Human Rights Campaign Foundation named Humana as one of the "**Best Places to Work for LGBTQ+ Equality**" for the eighth year in a row.

Fortune Magazine ranked Humana 2nd in the industry on their annual list of "**World's Most Admired Companies**" in 2021.

Military Times has named Humana a "**Best for Vets Employer**" annually since 2011, ranking 13th in 2020. Humana is the only healthcare company ranked in the top 20.

2.6.5.2 Strategies to Recruit, Retain, and Promote Medicaid Personnel and Leadership

Humana's **Diverse Talent Strategy team** oversees organizational efforts to recruit, develop, and retain diverse talent. Further, our **Medicaid Inclusion and Diversity Team** convenes senior Medicaid leadership to discuss ongoing opportunities, events, and training to create an inclusive and equitable environment companywide. We will rely upon the following strategies to ensure our staff consistently represent our Louisiana plan membership:

Recruit: **We will hire Louisiana-based associates across every region of the State to reflect the linguistic and cultural needs of our expected membership**. Our recruitment plan is based on recent data specific to Louisiana's Medicaid population, including Census data and Community Health Needs Assessments (HNAs), to prioritize creating an associate-enrollee demographic match. [redacted] We use **Balanced Interview Panels** to ensure our interview process includes adequate, diverse representation. Our leadership team blends state-specific knowledge and experience with expertise in Medicaid. Today our Medicaid market leaders have lived in the states they serve for an average of 30 years.

In our Florida market, over 55% of our enrollee-facing staff are bilingual, with 45% fluent in Spanish, the most prevalent non-English language spoken by our Florida enrollees.

Humana is a founding company partner of OneTen, an organization of cross-industry CEOs with a shared goal to train, hire, and advance one million Black Americans into family-sustaining jobs. Humana is the only healthcare company to have joined this pledge.

Retain: Humana focuses on creating an exceptional associate experience by engaging **over 90% of our enterprise-wide associates in feedback forums and engagement strategies that enhance our operations**. Humana's **Network Resource Groups** (NRGs) are associate-led forums that offer a powerful opportunity for leadership, inclusion, and career advancement and ensure underrepresented communities have a voice in our operations. Examples include IMPACT, our African American NRG, and Pride, an NRG for LGBTQI+ associates and allies. Our Pride NRG is currently leading efforts to enhance our clinical platform to integrate pronouns, gender-assigned at birth, and chosen name. In response to recent growth in our Medicaid business, we launched a Native American and Indigenous NRG in 2020. We regularly conduct internal reviews and external market benchmarking of associate pay. This includes a comparison of compensation trends between demographic classifications, such as gender and ethnicity, to ensure oversight of the equality of our practices.

Promote: Humana's **Talent Ready Pipeline program** readies diverse internal associates ready for immediate promotion or for a developmental move that could equip them with experience to prepare for a future promotion. A program manager collaborates with the associate, their leadership, the

recruiting team, and hiring leaders to advocate for career development opportunities. **Humana's Mentoring Circles** create formal, accountable structures for leaders to mentor a circle of associates guided by written and tracked goals to achieve by the end of the six-month program.

[redacted]

2.6.5.3 Organizational Practices to Ensure Culturally and Linguistically Appropriate Services

Humana's CLAS Program, guided by the **Enhanced CLAS Standards developed by the Department of Health and Human Services Office of Minority Health**, outlines our Medicaid P&Ps to ensure we deliver culturally appropriate care, including guidelines and expectations for our providers.

Organizational Approach: In addition to our tailored recruitment campaign described in **Section 2.6.5.2**, Humana takes extra measures that account for enrollees' spoken languages, communication abilities, and individual needs. Humana's **Concierge Service for Accessibility** provides interpreters and alternative formats to enrollees who request or indicate a preference for communications to be delivered in a non-English language and works to proactively resolve any barriers to care. Enrollees can self-refer to our Concierge Service, or be referred by a Humana associate, provider, or community partner. Once an alternative format is requested, this becomes a **"standing request" and we send all future enrollee communications in this format**. Through our Concierge Service, our proficient interpreters regularly contact each identified enrollee to read their communications over the phone, assist in arranging healthcare services, and understand their health care needs. Further, all enrollee-facing associates have access to resources to help facilitate the assessment and care planning process for non-English speaking and nonverbal enrollees. Where possible, we assign enrollees a Case Manager who speaks their preferred language; if this is not possible, our Care Coordination team engages an interpreter. Our translation and interpretation services include more than 200 languages and American Sign Language (ASL) in person or virtually. We regularly translate enrollee materials into the most prevalent languages across our membership. For enrollees who are visually or hearing impaired, we use teletypewriter, braille, and other interventions to facilitate full engagement.

> In August 2020, Humana joined EqualAI's Pledge to Reduce Bias in AI. Humana is the first and only payer to have joined this pledge, which identifies actions within a company's control that they can commit to changing quickly to create a tangible impact in our society, ultimately reducing unconscious bias in the development and use of artificial intelligence. All of Humana's predictive analytics models have passed the AI bias detector.

Provider Approach: We employ industry leading best practices within our P&Ps to hold our network providers to the same standards we hold ourselves, to support the delivery of CLAS; see **Table 2.6.5.3-1**:

Table 2.6.5.3-1: Approach to Ensuring Providers Deliver CLAS

Network Development: Humana's **Network Development Plan** prioritizes recruiting diverse providers who align with the cultural preferences of our enrollees. During contracting, we target providers with unique cultural and linguistic

specialties and ensure we include providers who can serve enrollees with physical and intellectual disabilities. All provider contracts require providers to treat Enrollees without prejudice.
Matching Enrollee and Provider Needs: Through our credentialing process, we collect data on provider gender, race, ethnicity, and languages spoken. Provider language and gender information is available in the online and print provider directory, in English and Spanish (other languages available upon request), enabling enrollees and associates to select practitioners that are best able to meet their needs. The online provider directory allows enrollees to filter by language and gender. Our primary care provider (PCP) auto assignment factors in language.
Provider Support: In addition, providing education on CLAS, we provide training on CLAS to providers and work with them directly to understand the needs of their panel and assist them in establishing P&Ps and infrastructure to deliver CLAS consistently. **Providers can use Humana's Practice Transformation Fund to enhance their language and accessibility services**, such as hiring bilingual staff or interpreters.
Ongoing Monitoring: We regularly compare membership and provider demographic data against network access standards to identify areas for improvement to incorporate into our CLAS Work Plan. Our Kentucky market, identified a shortage of Spanish-speaking psychiatrists in regions with high concentrations of enrollees whose primary language is Spanish; we deployed targeted outreach and support to connect providers with enhanced language supports.

2.6.5.4 Capacity to Develop, Administer, and Monitor Completion of Training Materials

In addition to Cultural Competency training, we exceeded our goal for the year of 80% of director level and above participating in Disrupting Every Day Bias training. All departments achieved a completion rate of over 92% in 2020.

Humana Staff and Subcontractors: Humana requires all new associates complete cultural competency trainings upon hire, with annual refreshments and re-trainings as necessary. **Developed by our Learning and Development team**, the training includes modules on cultural sensitivity and responsiveness, CLAS standards, and health equity. All Humana leadership is required to complete implicit bias trainings. **Our Medicaid Culture, Engagement, Inclusion, and Diversity team recently refreshed our onboarding process to apply a lens of health equity to all training materials**. Training is **administered through the Humana Learning Center**, our enterprise-wide, centralized Learning Management System, which distributes training content, **monitors completion**, reports progress, and retains training documentation and data. [redacted]

Network Providers: **Our Provider Engagement team collaborates with Quality and Provider Performance Improvement teams to develop** our required orientation and annual trainings, which include sessions on **cultural competency, health equity, and implicit biases**. Our required cultural competency training addresses clear communication, based on the *Teach Back* and *Ask Me 3* methods: understanding subcultures and how cultures influence healthcare experiences; and understanding the needs of people with disabilities and their caregivers. **Through our Provider Education e-learning library**, providers can access more than 340 co on children, youth, and adolescent populations and 20 courses about trauma-informed care. **We track and monitor training completion** and conduct outreach to providers out of compliance with required trainings to continuously refine our training. We regularly work with local universities and community-based organizations (CBOs) to create state-specific Continuing Medical Education on cultural competency and health equity. [redacted]

[redacted]

2.6.5.5 Engaging Stakeholders in Improving the Health of the Community

Humana has more than 20 years of experience working with community representatives to build trust and gain a deeper understanding of the populations we serve. Our various engagement forums **formally report to our market based Quality Assurance and Performance Improvement (QAPI) Committee** to ensure diverse perspectives are incorporated into our P&Ps, initiatives, and processes. Our **local Community Engagement team** engages partners in every parish to tailor our strategies for improved community health and addressing disparities to local circumstances. Our enrollee strategies are described in **Section 2.6.5.12**.

> "Humana has established strong ties to the community as a Medicare and commercial insurance provider, and we look forward to continuing to build on that existing relationship through their participation in the Louisiana Medicaid program."
> - Alma C. Stewart, Founder and President, Louisiana Center of Health Equity

Community Members: Humana engages community members through the following avenues:

- **Community Advisory Committee (CAC)**: Our CAC will organize a mix of participants, including local nonprofits, CBOs, providers, enrollees, enrollee advocates, and other stakeholders, for input on our programs and initiatives. We will rotate CAC meetings across all regions in the State, maximizing the opportunity for participation from representatives of different cultural and socioeconomic groups.
- **Listening Sessions**: To provide a more frequent and informal forum for enrollee and stakeholder input, Humana will host **Listening Sessions in every region of the State throughout the year**, at our five Humana Neighborhood Centers and community partner locations to meet our enrollees and community representatives where they are. **We have already met with the Urban League and the Legislative Black Caucus to kick-off our Louisiana Listening Sessions**.
- **Ongoing feedback** reported through enrollee and community-facing associates

Our Florida plan recently partnered with a local non-profit to launch an educational campaign to support Black mothers and babies by enhancing health literacy on the prevention of low birthweight births, prenatal care, BH, and the importance of nutrition and exercise. We created targeted content for World Mental Health Day to address mental health while pregnant in the midst of COVID-19 and racial injustice. **Via this campaign, we saw increases from 9.1% to 53.1% in pregnant women intending to discuss nutrition and 18.2% to 56.3% in pregnant women intending to discuss breastfeeding with their Providers. Results showed an increase of more than 90% in understanding low birth weights and over 37% increase in understanding the importance of exercise during pregnancy.**

Engaging Healthcare Providers: Our robust, Provider Support team engages providers through direct engagement strategies and reports provider feedback on an ongoing basis. We also host **Provider Advisory Councils** (PACs) in each of our Medicaid markets. In Louisiana, we will ensure PAC participation from a variety of provider types, including behavioral health (BH) providers and OB/GYNs, as well as at least one provider from each region. [redacted]

2.6.5.6 Using Community Health Workers, Peer Support Specialists, and Doulas

Humana currently utilizes Community Health Workers (CHWs), Peer Support Specialists, and doulas across our Medicaid programs; we describe our approach in **Table 2.6.5.6-1**.

Table 2.6.5.6-1: Experience and Approach to Using CHWs, Peer Support Specialists, and Doulas

Role	Experience and Approach
Community Health Workers (CHW)	These highly localized staff cultivate relationships with enrollees, community stakeholders, and providers and connect enrollees with critical community programs. We hire CHWs from the communities they serve, based on their strong ability to locate and engage enrollees, provide culturally appropriate supports, and connect with CBOs in their assigned region. CHWs perform feet-on-the-street functions targeting high-risk and unable-to-contact enrollees to connect them to appropriate resources. In our Wisconsin plan, our CHWs have achieved significant improvements in connecting enrollees to stable housing. Milwaukee is routinely listed as one of America's most segregated cities and evictions are common. **Since 2019, over 100 Humana enrollees who received housing assistance through CHW engagement remain in stable housing to this day**. [redacted]
Peer Support Specialists (PSS)	We connect enrollees with BH needs, including pregnant enrollees and those with substance use disorder (SUD), with an in-person Peer Support Specialists PSS to assist with recovery planning, skill building, counseling, relapse prevention, social determinants of health (SDOH) support, and health education. We engage the PSS in the enrollee's Interdisciplinary Care Team to promote collaboration. In Louisiana, we will work with local advocacy groups, including **local National Alliance on Mental Illness chapters, Mental Health America, and family advisory councils to develop and expand PSS supports**.
Doulas	Doulas support our pregnant enrollees and their families in prenatal, postpartum, and pediatric care, connecting families to important community supports and providing individualized health education. We work with local organizations, focusing our efforts on underserved communities, to provide our enrollees with doula supports that match their cultural and linguistic needs. We describe our Louisiana approach in **Section 2.6.5.13.**
Measurement and Evaluation: Our clinical teams examine clinical and quality measures, satisfaction survey data, utilization metrics, care gap closure, SDOH referrals, and appointment adherence (including prenatal and postpartum care) to identify successes and areas for improvement. We stratify these metrics by various enrollee demographic factors and compare enrollees engaged versus not engaged to identify variations in care delivery and outcomes. [redacted] Program metrics will be formally reported to our QAPI Committee monthly to provide a forum for cross-functional integration.	

2.6.5.7 Engaging Medicaid Consumers and Trusted Messengers

We engage trusted messengers through the processes described in **Section 2.6.5.5**. We have established specific activities to engage diverse community voices to help inform our organization's approach to delivering culturally appropriate and equitable care to Louisianans, as described in **Table 2.6.5.7-1**.

[redacted]

Evaluating Effectiveness: Our Community and Provider Engagement teams monitor participation rates and engagement strategies to ensure our committees effectively assemble a representative set of perspectives that match the diverse needs of our enrollees. **We present our CLAS Program Description and Work Plan to our enrollees, providers, and CBO partners via these forums, leveraging their perspectives to shape our strategies and enhance our services to effectively address local health disparities.** Each committee will report directly to our **Louisiana QAPI Committee**. At each committee meeting, we update attendees on how their feedback has been incorporated into our quality improvement (QI) strategies.

2.6.5.8 Data Collection Procedures Related to Enrollees' RELD Status, and Geography

Data Collection: To supplement demographic data received directly from State enrollment files, we collect enrollee race, ethnicity, language, and disability (RELD) and geographic information through the comprehensive assessment, the HNA, interactions with enrollee-facing staff, a self-reporting form available through the online enrollee portal, intake forms for clinical programs, and data received from providers. We supplement our data intake processes with information from CBOs, local reports (such as community HNAs), and Z code submissions.

Using Data to Inform CLAS: We use enrollee RELD and geographic data to: ensure our CLAS are appropriately serving our membership; conduct ongoing monitoring of our provider network to ensure cultural responsiveness; and tailor our enrollee engagement strategies. We also stratify our quality and satisfaction metrics by RELD data to pinpoint disparities and identify root causes. Our approach to using RELD and geographic data to reduce disparities, described in **Section 2.6.5.10.**

2.6.5.9 Utilizing RELD and Rural/Urban Data to Improve Outcomes and Address Disparities

Humana incorporates RELD and geographic data in the development of our programs and initiatives. In our Florida market, recent stratification of hospital readmission rates revealed that sickle cell disease, a condition that disproportionately affects our Black enrollees, accounted for 15% of total readmissions. We forged a partnership with Johns Hopkins University to create a **Sickle Cell Center of Excellence** to develop best practices and disease-specific education to guide our interventions. As a result, we achieved a **7.2% decrease in readmissions** associated with sickle cell disease from 2017 to 2018. We describe our approach for Louisiana in **Sections 2.6.5.8 and 2.6.5.10**.

2.6.5.10 Stratifying, Analyzing, and Acting on Data Regarding Inequities in Care

Data Stratification: Our internal quality dashboards report and trend performance on all quality measures and sub-measures. Stratification of enrollee data by all demographic factors, including but not limited to RELD, ZIP code, provider group, and heat mapping, enables us to analyze our membership from a variety of angles and define populations for interventions.

[redacted]

Using Data to Address Inequities: Our approach to develop, maintain, monitor, and adjust initiatives, stems from the **Plan-Do-Study-Act** (PDSA) data-driven improvement cycle. We incorporate **continuous quality improvement** in our quality analytics to ensure we can conduct rapid root cause analysis and adjust our interventions on an ongoing basis. [redacted]

Table 2.6.5.10-1: Approach to Stratifying, Analyzing, Acting on RFP Measures

Measure	Approach
2.6.5.10.1 Pregnancy: Percentage of Low Birthweight Births	**Stratify**: By RELD, geographic data, age, provider, and delivery hospital **Analyze**: Understand the intersection of timeliness and frequency of prenatal care, RELD, neighborhood, and low birth weight births, understand correlation between postpartum visit completion and contraceptive care **Act**: Adjust approach to Moms First program; work with community partners and OB/GYNs to address disparities, such as our **NOEH CHW** program to increase access to needed services and provide individualized education; deployment of digital resources, such as the [redacted]
2.6.5.10.2 Contraceptive Care - Postpartum Women Ages 21-44	
2.6.5.10.3 Child: Well-Child Visits in the First 15 Months	**Stratify**: RELD, geographic data, rural versus urban, provider, and provider type **Analyze**: Understand relationship between performance and local variations, work with trusted messengers and enrollees and their families to understand barriers to care. Assess if enrollees receiving services at school-based health centers (SBHC) or other provider types have different rates than enrollees in similar geographies receiving care from other provider types to ensure appropriate care delivery. **Act**: [redacted]
2.6.5.10.4 Childhood Immunizations (Combo 3)	
2.6.5.10.5 Preventive Dental Services	
2.6.5.10.6 Immunizations for Adolescents (Combo 2)	
2.6.5.10.7 Adult: Colorectal Cancer Screening	**Stratify**: RELD, geographic, rural versus urban, provider group **Analyze**: Identify areas or populations with high incidence of cancer but lower rate of screening to deploy targeted screening campaigns
2.6.5.10.8 HIV Viral Load Suppression	**Stratify**: RELD, geographic, rural versus urban, provider, age, gender **Analyze**: Newly diagnosed enrollees or enrollees with an uncontrolled viral load to [redacted]
2.6.5.10.9 Cervical Cancer Screening	**Stratify**: RELD, geographic, rural versus urban, provider group **Analyze**: Identify areas or populations with high incidence of cancer but lower rate of screening to deploy targeted screening campaigns **Act**: Inclusion of colorectal cancer screening in VBP programs, participation in **Taking Aim at Cancer Louisiana**, quality outreach campaigns tailored to support improvement and customization in any RELD-identified disparities

2.6.5.11 Leveraging Data Analysis and Community Input to Address Outcome Inequities Experienced by Black Enrollees and Their Newborns

Robust data collection, stratification, and analyses allow us to identify when and where a disparity occurs. We describe the measures we propose to analyze in **Section 2.6.5.13**. We use our feedback mechanisms with trusted messengers to understand what is working well and where we can make improvements. [redacted]

- Our Community Engagement team will conduct targeted outreach to pregnant Black enrollees to promote participation in our **Enrollee Advisory Committee**.
- We will administer an **Enrollee Experience Survey** to Black moms following postpartum visits to assess their satisfaction with their care, enabling regular monitoring.
- [redacted]
- We will **incorporate external sources**, such as the Louisiana State Health Assessment Dashboard, the findings of the Louisiana Perinatal Quality Collaborative Reducing Maternal Morbidity Initiative, and recommendations of the Healthy Moms, Healthy Babies Advisory Council Report, [redacted]

Through routine reporting to our **Louisiana QAPI Committee**, we will integrate this feedback into our data analyses and evaluate the effectiveness of these strategies, continuously refine our approach, and implement targeted interventions to measurably reduce inequities experience by Black enrollees and their newborns.

Data Analysis and Community Input in Action: **Humana Healthy Horizons is making an intentional commitment to reduce the health inequities faced by pregnant and new mothers across our Medicaid markets**. Humana's Bold Goal organization and our Chief Health Equity Officer, Dr. Nwanda Olayiwola, M.D., MPH, FAAFP, sought to engage a trusted community partner to develop a highly localized, person-centered program to reduce disparities. Based on their proven success and highly localized approach, Humana chose to partner with **Volunteers of America (VOA) to develop and scale a Family Focused Recovery (FFR) program for pregnant enrollees with SUD nationwide**. Beginning in our Kentucky market, we further invested in this model based on thorough analysis of national, local, and membership-specific data, as well as feedback gleaned from VOA's local expertise and broad community reach. Through this program, mothers and their children remain together during treatment, which significantly improves physical, BH, and SDOH outcomes. In Kentucky we saw: 25% increase in treatment completion rates compared to traditional service programs; 84% of women did not have new Department of Children & Family Services cases opened during treatment; and 67% of infants did not require NICU services. Based on community feedback from our Health Equity Listening Tour and local data analyses, we believe this program will drive significant improvements in maternal health disparities experienced by minority mothers in Louisiana. **Humana will expand our FFR program with VOA into Louisiana upon contract go-live**.

2.6.5.12 Using Feedback from Enrollees and Their Family Members

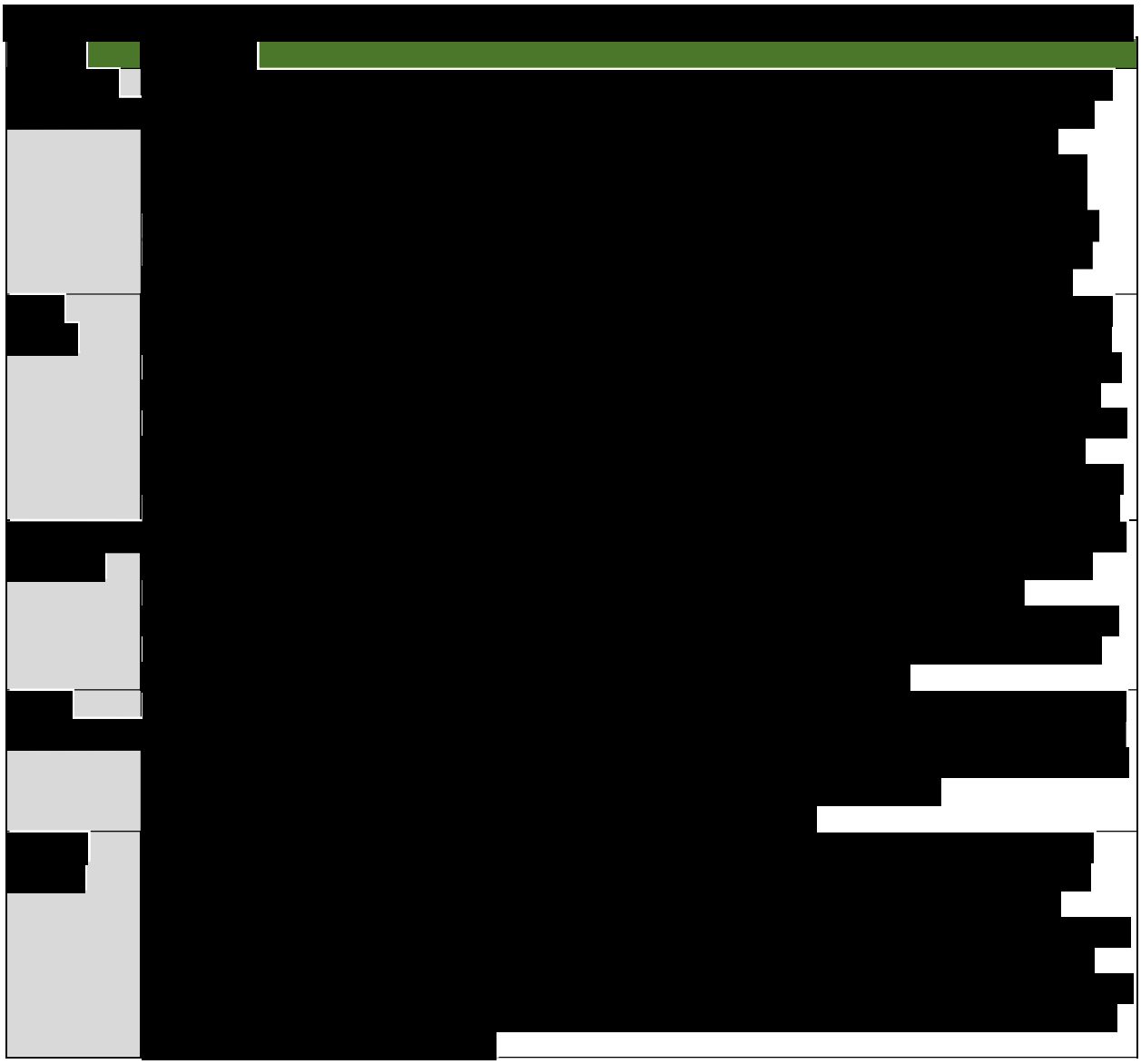
Through **formal reporting to our QAPI Committee,** we ensure enrollee feedback and data gleaned from across operational areas is aggregated, analyzed, and incorporated into our P&Ps, initiatives, and processes. We will collect and analyze enrollee feedback through the following mechanisms:

- **Our EAC** will convene a diverse set of representative enrollees in a formal, ongoing feedback loop.

Our local Community Engagement team will conduct thorough analyses of the local population based on available data and input from community stakeholders to drive our enrollee recruitment strategy. **We will host quarterly EACs in a different region of the State at a CBO or Humana neighborhood location to maximize participation**. We will update all meeting attendees on how their feedback is incorporated in our QI strategies.

- **Satisfaction data** collected through CAHPS© surveys, satisfaction with clinical programs surveys, Voice of Consumer surveys conducted after all Call Center interactions, and routine Pulse Surveys. **In our annual CAHPS survey, Humana will oversample identified minority groups** if initial results provide inadequate information to draw conclusions to inform programming for these groups.
- **Trending of operational data**, including Grievance and Appeals and language line utilization
- **Qualitative feedback** reported through enrollee-facing staff, including Case Managers and CHWs

Examples of using enrollee feedback to improve our operations, detailed in **Table 2.6.5.12-1**.



2.6.5.13 Outcome Measures to Improve Pregnancy and Birth Outcomes for Black Enrollees

We will implement the initiatives described in **Table 2.6.5.13-1** in Louisiana prior to Contract go-live and will monitor their effectiveness through the corresponding outcome measures.

2.6.5.14 Experience and Approach to Engage Parents/Adolescents in Decreasing Disparities

With experience serving over 400,000 children across our Medicaid programs, Humana understands the vital role that early, age-appropriate screenings play in the identification of pediatric health needs and the specific targeted interventions that nurture lifelong healthy behaviors. [redacted] collaborate to ensure we administer EPSDT benefits in a timely and equitable fashion. Our previously described data analytics and community input strategies, described in **Section 2.6.5.7**, enable us to tailor our strategies to the needs of our Louisiana pediatric enrollees and their families.

2.6.5.14.1 Well-Child Visits and Vaccination Rates for Children and Adolescents

Experience: Examination of our utilization and encounter data revealed that 2,525 pediatric enrollees in the Southern regions of our Florida Medicaid population had no evidence of primary care visits in the

previous 18 months. We subsequently developed an **in-person outreach campaign**, providing field-based staff to perform home visits to those enrollees. To ensure an understanding of local cultures and socioeconomic dynamics, the field staff was recruited from the communities they were in to conduct outreach. During home visits, field staff assisted with PCP appointment scheduling and provided a list of any needed screenings or gaps in care to take with them to the appointment. The field staff also helped with transportation, PCP assignment changes, and referrals to SDOH resources. Upon completion of the campaign, **529 enrollees closed the gap for access to primary care, achieving an average of 4.5 times more other required preventive services and treatments** than the remaining pilot enrollees. These differences in services included 6.5 times more wellness exams, 50% more young child immunizations, and 52% more adolescent immunizations.

Proposed Approach: We will implement the following initiatives in Louisiana:

- [redacted]

2.6.5.14.2 Preventive Dental Services for Children and Adolescents

Experience: In our Florida plan, Escambia Community Clinics (ECC), a federally qualified health center (FQHC) that includes pediatric, dental, and family practice providers, shared that children in underserved communities were not receiving critical preventive dental care. As a result, we assisted ECC in procuring a mobile dental clinic to enhance dental care delivery. Our regional Community Engagement leader, who also sits on the local parent-teacher association board, worked with the local school district to connect schools and children to ECC's mobile clinic to improve access to dental services directly at schools, including oral health exams and sealants. **More than 1,140 children received approximately 2,600 total services since program launch**. Through Humana's support, more than 20 schools have participated in the initiative. We continue to build on the success of this collaboration by expanding into additional schools, after-school day care, summer camps, and more.

Proposed Approach: Prior to go-live, **we will work with LDH and the dental PBM to share real-time outcome and utilization data for pediatric dental care**, to ensure all parties have the most complete data to conduct analysis, stratification, and to tailor our approach. We will implement the following initiatives, ensuring coordination with LDH, the dental PBM, and local schools and FQHCs:

- [redacted]

Humana sets up a table at the Makin' Groceries event, July 23, 2021. Associates were on hand to share giveaways and answer questions about the available services.

Section 2.6.6

Care Management

Humana

Healthy Horizons™
in Louisiana

2.6.6 2.6.6 Care Management

Humana Healthy Horizons in Louisiana has reviewed and confirms adherence to the Louisiana Department of Health (LDH) expectations and requirements in **RFP Section 2.6.6, Model Contract Section 2.7 Comprehensive Care Management Program** and **MCO Manual Part 5: Care Management,** to offer an integrated, person-centered Care Management (CM) program to support enrollees, regardless of age, based on an individualized assessment of care needs. Humana will follow the criteria set forth in 42 C.F.R. §483.100 - 138.

2.6.6 Humana's Approach to Meeting Care Management Requirements

Humana's human care approach to managing enrollees' care needs encompasses a set of activities to improve patient care and health outcomes, and reduce the need for unnecessary medical services. Our person-centered model enhances coordination of care, eliminates duplication, and engages enrollees and caregivers in managing their chronic health conditions. As discussed below, our approach comprises four key components:

1. **Person-Centered Collaborative Approach**: Our **Empowered Care Plus (Empowered Care+)** whole-person health model supports enrollees through fully integrated, co-located physical health and behavioral health (BH), and social determinants of health (SDOH), placing the enrollee at the center of the model and emphasizing their involvement at every step of their healthcare journey.
2. **Advanced Data Analytics**: Humana's proprietary **Integration Plus Population Health (Integration+) platform** uses data analytics and predictive modeling to stratify enrollees, identify at-risk individuals who could benefit from CM, outreach and support, and continuously monitors them for a change in condition.
3. **Integrated and Specialty Assessments:** Our integrated assessment contains physical health, BH, and SDOH elements. It drives our person-centered Empowered Care+ model in the care planning process, incorporating results from the Health Needs Assessment (HNA) and our other comprehensive assessments, and facilitating engagement with enrollees. Our care planning process uses the specific, measurable, actionable, realistic, and time-oriented (SMART) goal framework. We share the enrollee's Plan of Care with the Interdisciplinary Care team (ICT), with the enrollee's permission.
4. **Ongoing Monitoring:** Our Integration+ platform monitors enrollee condition changes, and alerts the CM team and enables our Case Manager to track activity daily. Case Managers maintain regular, in-person, and telephonic contact with their enrollees to address care gaps and ensure timely delivery of services.

Humana's Person-Centered Care Management Approach

Our person-centered, Empowered Care+ whole-person health model puts the enrollee in the center of every decision with their Case Manager as their single point of contact. As illustrated **in Figure 2.6.6-1 Comprehensive Care Management Team Model**, our Case Managers, registered nurses (RNs), and licensed mental health professionals (LMHPs) provide clinical management, intensive monitoring, and follow-up of high-risk enrollees. Our Case Managers oversee the Plan of Care development and confirm appropriate referrals via timely two-way transmission of service information, beyond what the primary care provider (PCP) provides. The Case Manager leads the ICT meetings; works with our Housing Navigators and community health workers (CHWs) to address enrollees' SDOH needs; and supports safe transitions between institutional and community care settings. Our Case Managers' key objective is to help our enrollees achieve their best health through integrated care delivery, and then move to self-management. We use data analytics and enrollee experience to promote engagement while our Case Managers and providers encourage enrollee behavior change through proactive clinical outreach and increased access to PCPs, medical homes, and specialty care. We promote improved enrollee health by addressing the individual's risk factors that adversely affect their physical health and BH, such as

substance use disorder (SUD), SDOH concerns, and health disparities. Our integrated Comprehensive Care Support (CSS) team will exchange information that supports our enrollees with co-occurring, complex needs. Our Integration+ platform supports efficient coordination, delivery, and direct management of covered physical health, BH, and SDOH services to address gaps in care, automate care planning, monitor compliance, and improve patient outcomes. Between November 2019 and March 2020, our Florida Managed Medical Assistance CM program achieved the following positive CM utilization changes for our Medicaid enrollees:

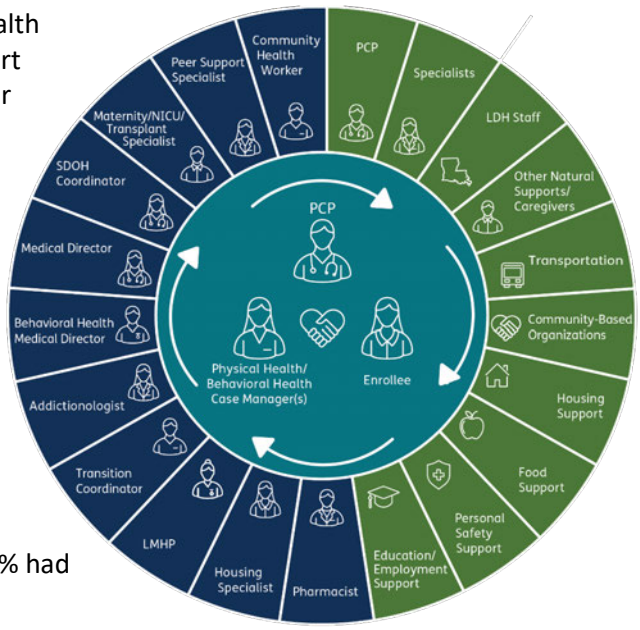


Figure 2.6.6-1: Comprehensive Care Management Team Model

- **Diabetes:** 28% reduction in inpatient admissions; 95% had a PCP visit in the last year
- **Asthma:** 13% reduction in inpatient admissions; 93% had a PCP visit within the past year; 49% developed an Asthma Action Plan
- **Heart Disease:** 26% reduction in inpatient admissions; 97% had a PCP visit in the last year
- **Sickle Cell:** 11% reduction in emergency department (ED) visits; 85% had a PCP visit within the last year

Ongoing Monitoring to Meet Each Enrollee's Individual Needs

Our Case Managers monitor their assigned enrollees, in-person or by phone to confirm and reinforce the enrollee's SMART goal progress and outcomes. The Case Manager also monitors automated care gaps and system-generated alerts based on data analysis and information received from claims, assessments, and community data. We also use our data algorithms system monitoring to identify individuals with a change in condition through: [redacted] hen combined, these monitoring systems can identify enrollees who may qualify for Case Management. Once our data analytics identify the enrollee, the Integration+ platform automatically generates a CM referral and sends it to the appropriate Case Manager for outreach. Finally, we monitor contract compliance using the CM and Leader Dashboards, which calculates the minimum next contact and reassessment time frames. Our Quality and Compliance teams review our enrollee CM files, including assessments, Plan of Care, and contact documentation to ensure the quality of our work and to help identify any training needs.

2.6.6.1 Process for Ensuring Successful Completion of HNA Within Required Time Periods

We will complete enrollee HNA screenings within 90 calendar days of the enrollment effective date as required by 42 C.F.R. §438.208(b). The initial welcome call and outreach includes the HNA. We will leverage in-person, telephonic, web-based, and print methods to engage enrollees in completing the HNA. If our initial outreach attempt is unsuccessful, we will make three attempts (and document our efforts), at different times of the day and on different days of the week. For enrollees identified as **high risk, such as individuals with chronic conditions, pregnant women, or people with special needs**, our CM team will engage the enrollee and assist in completing the HNA, in anticipation of their inclusion in CM. Our CHWs will go into the community and attempt to locate and conduct in-person outreach to unable-to-contact (UTC) enrollees whom we identify for CM. When our CHW successfully engages a UTC enrollee in CM, they conduct a three-way call with the assigned Case Manager to facilitate a direct

introduction and schedule a time to complete a comprehensive assessment. We have been successful completing the HNA for our Louisiana and Illinois Medicare Advantage (MA) members, and for enrollees in similar Medicaid markets, within the required time frames including:

- In Kentucky, we averaged 96.59% health risk assessment completion rate between March 2020 and December 2020.
- In Illinois, in 2020, we averaged 95% health risk assessment completion, and in the first quarter 2021, we averaged 99.2% completion rate within 90 days of enrollment, among those members who were willing to participate and who could be reached.

2.6.6.2 Tools to Identify Individuals Who Can Benefit from Case Management

We use risk stratification sources to identify enrollees who may benefit from CM including the HNA and comprehensive assessment, medical and pharmacy claims and utilization data, New Member Predictive Model (NMPM), referrals from inpatient physical health and BH facilities, and the nurse triage or BH crisis lines. When an HNA flags conditions that may benefit from Case Management, such as pregnancy, comorbid conditions, or SUD, a Case Manager reaches out to the enrollee and completes a comprehensive assessment. We use a variety of data sources to identify an enrollee's emerging needs: Flags on LDH enrollment files via the 834 report; referrals from the enrollee, family members/caregivers, PCP, or specialists; State Medicaid and other LDH staff, and Humana and community agency staff. We also use health information exchange and medical history data, when available, predictive modeling and risk stratification. This comprehensive data set is more reliable than traditional identification methods that over-emphasize hospital admissions and acute diagnoses, or under-emphasize issues that suggest disability or frailty. Our predictive model provides risk stratification for enrollees whom we identify as a potential candidate for CM. Our proprietary NMPM compiles and analyzes the enrollee's data elements and assigns initial risk stratification within 30 days of enrollment, based on multifactor claims analysis. The predictive model notifies the Case Manager when there are modifications in stratification that could indicate a change in their assigned enrollee's condition. The NMPM identifies new enrollees for initial Case Management engagement and outreach. As described in our response to **Model Contract Section 2.6.6.4**, we maintain three CM Tiers and Transitional CM for enrollees moving between care settings. Case Managers determine the final risk and CM Tier for the enrollee, which guides our enrollee engagement by CM tier and risk score. Once stratified, the enrollee's Plan of Care is completed within 30 days of identification for Tier 3 or Tier 2, and within 90 days for Tier 1.

In compliance with **Model Contract Section 2.7.2.1**, we will attempt to conduct LDH-developed, common survey-based HNA, as part of the Enrollee Welcome Call, to identify physical health, BH, and functional needs. During the HNA or comprehensive assessment, any noted key triggers automatically refer the enrollee for CM. Our **Integration+ platform identifies enrollees in need of outreach using** data algorithms and predictive models from claims, diagnosis, utilization patterns, and community factors to inform initial risk stratification. This stratification drives Case Management assignment and matches the enrollee with the Case Manager who can best assist them in closing gaps and obtaining their best health. For example, we will match an enrollee who has a primary BH concern with a LMHP Case Manager, and an enrollee with a primary physical concern to an RN. We pair enrollees whose needs are primarily related to SDOH or care coordination with a social worker. All Case Managers can access additional physical health and BH specialties within their team to support their work with the enrollee.

2.6.6.3 Engaging Enrollees Who May Benefit from Case Management

Humana uses multiple methods to engage enrollees, or a child's parent/legal guardian or caregiver, who may benefit from Case Management, including informational mailings, outreach campaigns, care coordination, and digital communication solutions. In alignment with Triple Aim, we actively engage our

enrollees to improve health outcomes, and support self-management of chronic conditions, resiliency, and recovery, which ultimately reduces costs.

For those enrollees with active care gaps, no recent PCP visit, or an incomplete HNA, our enrollee outreach campaigns include regular telephonic outreach, alerts via Humana's digital platforms, including the MyHumana Enrollee Portal, our Go365 mobile application, and email.

We perform telephonic outreach, and if we are unable to locate a high-risk enrollee who may benefit from Case Management, we enact our UTC protocol, using locally based members of the CM team to assist in connecting and engaging with those enrollees. Our enrollee outreach and engagement for enrollees with special health care needs (SHCN), high-risk pregnant women, or new enrollees who were in CM prior to enrolling with us, begins with an in-person visit to further engage the enrollee in their care conducted by our local CHW. We also accept CM referrals from enrollees; PCPs; BH and other providers; State staff in LDH and other Medicaid departments; the DOJ, Office of Juvenile Justice, and Department of Children & Family Services (DCFS). All of our enrollee-facing staff receive training on motivational interviewing, person-centered care, and cultural competency to support our engagement efforts. Our Enrollee Services Call Center staff train on CM benefits, and offer direct access for enrollees who request a referral or assistance with CM. Our CHWs, Peer Support Specialists, and Case Managers can request assistance from our Concierge Services for Accessibility Representative to use a translator to facilitate communications to engage enrollees in their local communities. Our Louisiana Enrollee Engagement team will also leverage our trusted community partners, including local faith-based organizations and community-based organizations (CBOs), such as the [redacted] Humana's five local Neighborhood Wellness Centers provide additional engagement opportunities for enrollees who may benefit from CM including providers offering SDOH screening, and identification of clinical and BH conditions that may indicate a need for CM. In alignment with the Model Contract, we will also deploy local CHWs as part of our CM team across the state to provide critical feet-on-the-street assistance locating, engaging, and coordinating enrollees' physical health, BH, and SDOH services, in alignment with our provider community, Case Managers, and CBOs. For example, **in New Orleans in 2019, we increased collaboration with providers to identify and integrate SDOH into the clinical setting and engaged with the New Orleans Health Department, working with community stakeholders to form a Community Health Improvement Plan**. We educate and reimburse providers for screening and identifying SDOH barriers. We recruit our CM team members from the communities they serve and often lead collaborative outreach efforts with providers in their communities to locate and engage enrollees.

2.6.6.3.1 Specific Considerations for Children and Youth with Special Healthcare and BH Needs

We engage children and youth with special healthcare and BH needs in CM through our enrollee outreach process described previously, and work with the parent or legal guardian to complete the assessment. If our first three telephonic and mail engagement attempts are unsuccessful, we will attempt in-person outreach to locate and engage the high-risk enrollee for CM to complete the assessment. The Case Manager will include CHWs and Peer Support Specialists in the enrollee's Plan of Care, with enrollee consent, as applicable. We have learned we can improve enrollee engagement by linking an individual with SHCNs to a local CHW who is familiar with the community and available resources, or a Peer Support Specialist who shares like experiences. We train our CHWs in motivational interviewing, health education, and care navigation, which promotes enrollee engagement and participation in CM. This process also allows us to identify other family members and caregivers who need additional supports in the care of enrollees with SHCN. To address priority special needs and SDOH concerns an enrollee may have, we will identify and document their natural supports then work to increase the resources they can access. Our CM team will fill care gaps for our children and youth with

SHCNs through CBO services such as the **Jefferson Parish Human Services Authority for BH and SUD support;** supported employment assistance, social inclusion, and crisis intervention; and the **Northeast Delta Human Services Authority's** supports for disability-related expenses; community-based housing, crisis assistance, BH support services, peer support; and employment training and placement. We engage children and youth enrollees with BH needs in CM through **our partnership with the National Alliance on Mental Illness (NAMI).**

2.6.6.3.2 Considerations for Pregnant and Postpartum Enrollees with SUD and Their Newborns

Louisiana's maternal mortality rate of 58.1 deaths per 100,000 births is the highest in the United States and is approximately four times higher for Black mothers than it is for white mothers, according to World Population Review. **All pregnant enrollees will be eligible to join our maternity CM program Moms First, led by RNs with cultural, maternity, and/or pediatric specialization. Moms First features contact frequencies and modalities targeted to each individual enrollee's acuity level**. Our target population is pregnant women age**s** 12-51 who are struggling with opiates, alcohol, nicotine and/or other substances, whom we will identify through medical, BH, and prescription claims, State files, and referrals from hospitals, providers, and CBOs. Through Moms First, our enrollees with one or more risk factors will receive CM outreach tailored to their individual needs. We prioritize engagement with pregnant enrollees with SUD to establish network OB/GYN relationships early and encourage CM referrals for high-risk pregnancies. Our CM team will work to locate pregnant enrollees we cannot reach to engage them in Moms First.

evidence-based addiction services through telemedicine, providing our adult enrollees in all service regions

[redacted]

2.6.6.3.3 Specific Considerations for Children Who May Have Unique Cultural and Linguistic Needs

Humana offers specific consideration for LDH enrollees, including children from immigrant families, who may have unique cultural and linguistic needs. For example, the Case Manager will identify and be sensitive to the enrollee and the family's unique linguistic requirements, and cultural and religious traditions. Using telephonic or in-person communication, the Case Manager assesses literacy and nonverbal skill sets (for hearing impaired or nonverbal children with unique cultural and linguistic needs). The enrollee's Case Manager will work with our Concierge Service for Accessibility to provide language or American Sign Language assistance, and address their cultural or linguistic needs, to help eliminate barriers to care. Humana regularly translates Plans of Care into other languages upon request, and our Concierge Service for Accessibility assists enrollees and Case Managers in arranging services. Enrollees who are non-English speaking are assigned a Case Manager who speaks their preferred language, if possible. If we do not have a Case Manager who speaks the enrollee's language, we will ensure an interpreter participates in all interactions or information is provided in their written language. For enrollees who are visually or hearing impaired, or who are nonverbal, we will use telephone typewriter (TTY), braille, and other interventions to facilitate full engagement in the Case Management process. We offer bilingual enrollee services and CM staff and health literacy advocates to inform our organization-wide effort, include language as a factor in PCP assignment, promote diversity in enrollee and community advisory boards, and coordinate with the Office of Community Partnerships and Health Equity and LDH in a workgroup to address and correct health disparities.

The enrollee's Case Manager will work closely with the enrollee and their family to understand their individual cultural needs and incorporate them in the enrollee's Plan of Care. Humana is committed to hiring and promoting culturally and linguistically diverse leaders and associates representative of our enrollees' cultures and ethnicities. We train our enrollee-facing staff in sensitivity to diversity, disparities, and the delivery of appropriate and effective services. We assess the ethnic composition, linguistic and cultural needs of our membership and develop the appropriate provider network by contracting with providers who have diverse backgrounds and linguistic skills, confirming we have

network providers who speak the language of the communities whom they serve or have an interpreter available for in-person and telephonic/telehealth visits. We offer annual cultural competency training to our providers and associates, in addition to LDH's required associate cultural competency training and attestation. Humana's Concierge Service for Accessibility and Health Literacy Advocates will provide assistance navigating physical health, BH, and SDOH services for enrollees and families who may have unique cultural and linguistic needs. Our enrollees access these services through our toll-free phone number, our Concierge Services Line, on Humana.com, our network providers, through our Enrollee Services Representatives, and CM team.

Resolving Newborn Health Issues for Immigrant Family

A newborn infant Medicaid enrollee, whose family was newly arrived from Asia and spoke only Hindi, had hyperinsulinism, a rare condition that could result in life threatening hypoglycemia. The enrollee's case was complicated because no Florida provider could manage this case, and the experts for this disorder were at Children's Hospital of Philadelphia (CHOP). The Humana Utilization Management and CM team arranged round trip, fixed wing transport to CHOP and an at-home treatment program. The child required 24/7 home nursing to monitor blood glucose and give intravenous fluids to correct the condition. Because of the family's language requirements, our staff had to locate nurses who either spoke Hindi, or who could work at the family home with access to a Hindi translation service. The child is now approximately three years old and doing well, even though she still requires 24/7 nursing, and the family is now well adjusted to their new home.

2.6.6.3.4 Considerations for Pregnant Enrollees Prior to Delivery to Ensure Pediatric Care is Established

When we are notified of pregnancy through an indicator on the 834 report, we mail a letter to encourage the enrollee to establish care with a pediatrician and engage in our **Moms First CM program to provide assistance with identification and connection with a pediatrician prior to delivery.** We offer pregnant and postpartum enrollees 24/7 access to a video-enabled call-routing system that connects to a lactation consultant or a physician extender within 30 seconds or less. This connection enables push notifications and reminders to prompt the enrollee to establish pediatric care prior to delivery. Our doulas can help enrollees in establishing pediatric care prior to delivery, and our local CHWs will work with our pregnant enrollees to access CBOs, such as The Family Tree, and reinforce the importance of healthy children from birth. We will educate our pregnant enrollees about the importance of pediatric care through culturally informed programs that support the parent(s) in the development of coping skills and stronger family systems and BH improvement.

2.6.6.3.5 Specific Considerations for Enrollees at Risk for Rapid Repeat Birth

In Louisiana, the 2018 overall teen (15-19) birthrate was 27.2%, with an average repeat teen birthrate of 16.8%, according to LDH. Humana understands that teens who are at risk for rapid repeat births are also

at risk for adverse prenatal, perinatal, and postpartum outcomes. We developed specific considerations to engage these enrollees in CM while they are in prenatal care, upon delivery, and through their postpartum visit. We link clinical contraceptive services with nonclinical activities that build planning skills, confirm the enrollee understands how contraceptives work in determining positive life outcomes, and provide education, mentoring, and goal setting to the enrollee and her natural supports. Humana promotes the use of long-acting reversible contraception (LARC) to help prevent rapid repeat pregnancies. We incentivize our OB/GYN providers for detecting pregnant enrollees early, providing LARC, and increasing rates of prenatal and postpartum visits. The Case Manager will connect enrollees to SDOH resources, support organizations, and CBOs that can provide support. For example, in Region 3 we would refer enrollees to Believe in Youth - Louisiana (BY-LA), a trauma-informed teen pregnancy prevention program administered by the Institute of Women & Ethnic Studies, which teaches age-appropriate emotional and sexual health to young people. [redacted]

2.6.6.3.6 Specific Considerations for Adolescents Transitioning to Adulthood

We have developed specific supports for adolescents who are transitioning to adulthood, recognizing enrollees need assistance in developing needed life skills and obtaining the necessary resources to help them reach their potential. We monitor the State's 834 file for enrollees close to the date when they will transition to adulthood (CHAMP-Child age 19, Foster Care age 21, and former Foster Care 26), and we send a reminder letter including information about their current benefits and opportunities to enroll in Medicaid as an adult, if applicable. We recognize children who are transitioning out of the Medicaid or juvenile justice systems are at high risk for poor outcomes such as homelessness, untreated psychiatric or medical conditions, and even shortened life expectancy, and we will work with those enrollees in CM who require individualized care, education, and support to start managing their own care. Humana will partner with DCFS to access those services and CBOs such as Covenant House. We share educational materials provided through the KidsHealth® library and Healthwise, and referrals to classes conducted by our Louisiana Medicaid Community Engagement team at Humana Neighborhood Centers and other community centers. Our Case Managers support and effectively manage enrollees with high-risk, complex care needs, and remain in direct contact with the enrollee or their authorized representative, and their providers as appropriate, to facilitate any necessary medical transfers. Our comprehensive, team-based approach incorporates High-Fidelity Wraparound and natural supports, as well as services through our internal and external CBO partners. We encourage enrollee self-management to direct their own physical health and BH care, and we offer assistance to navigate the healthcare system and find solutions to meet their SDOH needs. Our goal is to support and guide our adolescent enrollees who are transitioning to adulthood through this critical stage of life, providing them the tools and resources to maintain or improve their health and well-being, such as:

- **Transitional Services:** SDOH assistance with housing, education, and employment
- **Independent Living:** Health Navigators and Independent Living Coordinators, an Independent Living Skills Toolkit, and parish-based CBO contact list
- **Higher Education & Workforce Development**: Inclusion in the Humana Workforce Development Program, and a Louisiana Education Training Voucher program
- **Care Coordination**: Assistance to navigate the healthcare system, education on available benefits, including VABs, disease-specific education, and self-management support
- **CHW Support**: With enrollee consent, we provide assistance from a CHW or Peer Support Specialist, referrals to resources to address SDOH, including use of the Louisiana Humana-United Way Community Resource Directory

- **PCP Assignment**: Assist in assigning PCP and specialty providers, including BH clinicians, who are familiar with adolescents/young adults' unique needs and preferences, including cultural and linguistic choices. We also offer behavioral health care coordination, outpatient BH providers, intensive home base treatment, mobile response stabilization service providers, and in-network school-based health centers.

2.6.6.3.7 Specific Considerations for Children with Type 1 Diabetes Mellitus

Our Case Managers will work with the enrollee and their parent/legal guardian or caregivers to manage the child's condition and provide health education on topics including, but not limited to insulin delivery, symptoms of ketoacidosis, hypoglycemia, how to recognize symptoms of complications, and how to access our 24-hour nurse triage line to prevent or reduce ED usage. These enrollees are in CM and receive assistance with referrals to specialists who can address the physical health and BH complications that may occur. The Case Manager works with our SDOH Coordinators to ensure the enrollee and their parent/legal guardian or caregivers have access to fresh, appropriate food and transportation, provides parental supports and monitors for caregiver stress, and offers resources for parents, such as diabetes support groups. Our CHWs will help the enrollee and family engage in diabetes camps, support groups, and other organizations for children with type 1 diabetes mellitus and their families. We offer remote monitoring and provider-to-provider telemedicine consults (audio, visual, and telemonitoring) to providers delivering care to complex patients, particularly in rural and underserved areas without access to a range of specialty and BH services. We also provide an innovative digital therapeutic smartphone application to help enrollees with diabetes better manage their blood sugar levels. They can increase self-management of their diabetes through the individualized, real-time feedback and reporting of blood glucose, activity level, diet, and more. Our Case Managers receive a report of the enrollees' activity on the smartphone application to monitor the enrollees' condition and intervene as necessary.

Florida Teenage Enrollees with Type 1 Diabetes

We have had several Florida Medicaid teenage enrollees who were seen in the ED or hospitalized frequently for diabetic ketoacidosis. In these cases, our Utilization Management and CM teams worked with the enrollees' families, attending endocrinologists, PCPs and diabetic educators to arrange for glucose monitors that transmitted values wirelessly to providers. We also arranged for an insulin pump that interacted with the glucose monitor to adjust their insulin needs in real time. Simultaneously, our Case Managers arranged for the adolescents to see a therapist who specialized in caring for pediatric patients with chronic illnesses. As a result, the enrollees' Type 1 diabetes mellitus control improved, ED visits and admissions stopped, and their attitude toward their Type 1 diabetes mellitus diagnosis and their school performance improved.

2.6.6.3.8 Specific Considerations for Enrollees with Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) can change how a child learns, responds to stress, makes decisions, and can lead to the adult onset of chronic diseases, such as heart disease, depression, drug abuse, violence, and being a victim of violence, according to the Mayo Clinic. Humana has developed a tailored approach for enrollees with ACEs to address this critical public health issue. We administer a comprehensive physical health, BH, and SDOH assessment to determine if an enrollee is eligible for CM. This assessment incorporates ACEs screening and informs the integrated Plan of Care. Because ACEs can have lasting effects on health and well-being for many years beyond childhood, we train all enrollee-facing associates on trauma-informed care (TIC) to identify and support individuals who are affected.

[redacted] Our Case Managers also work with the enrollee and their ICT, including a BH provider, to build and strengthen the enrollee's resilience and help lessen the consequences of ACEs. Our evidence-informed peer recovery model includes face-to-face coaching from peers with lived ACE experience.

Regardless of race or ethnicity, economic hardship, a divorce, or separation of a child's parents/legal guardians is the most commonly reported ACE. **We are addressing** [redacted] Our Case Managers and CHWs provide additional enrollee support to develop caregiver knowledge and the application of positive parenting skills; reinforce enrollees' social and emotional health, close relationships with competent caregivers or other caring adults, and community supports that promote health and development. We help enrollees develop individual problem-solving skills, self-regulation abilities, and social connections by aligning them and their family with the appropriate BH provider and community support systems. These supports help enrollees feel safe more quickly after an ACE and help minimize its impact and facilitate development of coping skills when facing adversity.

2.6.6.3.9 Specific Considerations for Enrollees with Food Insecurity

The COVID-19 pandemic exposed long-standing inequities and vulnerabilities across Louisiana, with more than 1.6 million residents living in food insecure communities as of May 2020. Monroe and New Orleans rank highest with 65% of their residents living in food insecure areas, according to Urban Footprint. We work with CBOs, like the Food Bank of NE Louisiana, and provider partners to address food insecurities associated with increased risks of significant physical health and BH diagnoses. Using the HNA, we will identify new enrollees experiencing food insecurities. Through comprehensive assessments, our Case Managers will identify the specific health outcomes being influenced. We incentivize network PCPs to assess enrollees for SDOH needs, including food insecurity, using The Hunger Vital Sign™ two-question screening tool to quickly assess food needs. We train and empower our providers to connect their patients to resources in the clinic and with CBOs to address the identified SDOH gap. Once identified, enrollee Case Managers work with our CHWs to coordinate access to food security programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutritional Assistance Program (SNAP). Not all enrollees qualify for these programs, so we are committed to partnerships that address food insecurity, such as Feeding America. Together, we produced our Food Insecurity Toolkit to help providers, CBOs, and local agencies with food insecurity resources. The First Phase of the Acadiana Health Initiative, the Mobile Market, began on July 23, 2021 via a Humana and Humana Foundation community partnership with Second Harvest Food Bank of Acadiana. **The Mobile Market deploys each week to four, at-risk, Greater Lafayette Area communities, selling affordable and nutritious food, including fresh fruits and vegetables**. The Second Phase, scheduled to begin later this year, expands the program to offer flu shots and diabetic eye exams at the four Mobile Market stops.

2.6.6.3.10 Specific Considerations for Enrollees without Reliable Telephone Access

Many enrollees, especially in rural areas, do not have reliable telephone access. Although Medicaid enrollees in CM qualify for the SafeLink telephone program, they usually have a limited cellular data plan. **We are offering additional cell phone data across all regions as a VAB for enrollees in CM, to facilitate access to telephonic and telehealth services**. The 2020 Social Science Research Council's report reported a lack of broadband internet has emerged as an enormous barrier, especially in Louisiana's rural areas: 22% of households with no internet access are being left behind. In six rural parishes (East Carroll, Tensas, Madison, Claiborne, West Carroll, and Franklin), it is estimated more than half of households do not have internet access. [redacted]

health and SDOH disparities, not only for enrollees, but for the entire community. This solution enables enrollees to meet their PCP, BH providers, and specialists virtually, allows providers to close gaps in care, and improves HEDIS® preventive care outcomes. This program provides better access to Medicaid benefits and CBOs and supportive programs, addresses social isolation, improves health literacy, [redacted]

2.6.6.4 Identifying the Appropriate Tier of Case Management for Enrollees

Humana has reviewed and confirms adherence to requirements in **Model Contract Section 2.7.5** and 42 C.F.R. §438.208(b)(2)(i) to provide at least three tiered levels of CM and transitional CM. We use several objective measures and criteria to identify the appropriate CM tier, including State enrollment file 834 flags, referrals from PCP, family/caregivers/legal representatives, State and Humana staff, and community agency referrals. We use HNAs and comprehensive assessment, claims history (when available), predictive modeling, and identification/stratification data. We also incorporate specialty care provider referrals for physical health, BH, and SDOH needs, BH crisis line referrals, post-discharge outreach, Utilization Management and grievance and appeals data, and quality data from our Case Managers. **Our Integration+ platform, our primary identification tool for initial risk stratification, integrates all relevant data, creates, and/or** [redacted] By regularly reviewing this information, we can identify enrollees with emerging CM needs so traditional identification methods do not mask or over index on hospital admissions and acute diagnosis or under index disabilities or frailties.

Levels of Support Provided at Each Tier

Our Case Manager's clinical expertise paired with Humana's stratification process help refine an enrollee's risk level and CM tier that provides the appropriate core set of supports, as illustrated in **Table 2.6.6.4** Types of CM Support Provided in Each Tier, and referrals to our Louisiana Medicaid Community Engagement team's classes at our Neighborhood Wellness Center and other community centers. While all enrollees in CM may receive CHW or Peer Support assistance with the enrollee's consent, we will make referrals to community resources to address SDOH issues, including the Louisiana Humana-United Way Community Resource Directory. Our Case Managers identify the unique profile and level of support at each of Humana's CM Tiers.

Table 2.6.6.4 Types of CM Support Provided in Each Tier

Tier 1: Low-Risk Enrollees with Modifiable Health Behavior Choices, Well Care, Wellness and Prevention	
Profile	Children and expansion adults qualifying for CM who need SDOH or short-term care coordination, mild- or well-controlled BH conditions, combined with tobacco use, or obesity
Goal	Improved enrollee self-management, meeting care goals, promoting optimal health status, reducing barriers to care, and preventing adverse outcomes
Objective	Meeting care and SDOH goals
Supports	In-person HNA/comprehensive/home assessment/Plan of Care within 90 days of physical health, BH, or SDOH need identification; quarterly Case Manager-led CM meetings or as Plan of Care requires; CHW/Peer Support Specialist assistance; in-person Plan of Care update conducted annually, upon change in condition
Tier 2: Medium-Risk Enrollees Who Have a Stable Chronic Condition or Emerging Needs and Vulnerabilities	
Profile	Preterm/low birth weight infants, multisystem youth/foster care children, pregnant women, high/persistent unmet SDOH needs, toxic environmental exposure (e.g., lead), moderate BH condition, or pre-diabetic enrollees. **Inclusion Criteria:** Physical health, BH, or SDOH need that places the enrollee at risk for readmission; institutionalization/unnecessary ED visits within the last six months

Goal	Prevent institutionalization/adverse outcomes; meet care goals, self-management, and SDOH needs; reduce barriers to care and disease burden
Objective	No unplanned inpatient admission/unnecessary ED visit within last six months
Supports	In-person HNA/comprehensive/home assessment /Plan of Care within 30 days of identification of a physical health, BH, and SDOH need; monthly ICT and Case Manager-led CM meetings, or as Plan of Care requires; CHW/Peer Support Specialist assistance; in-person Plan of Care update conducted (at minimum) quarterly, upon change in condition, enrollee or ICT member request, and attestation to PCP/enrollee
Tier 3: High-Risk Enrollees Who Require High Levels of Support or Complex Care	
Profile	High-risk maternity; multiple chronic conditions; formerly incarcerated enrollees, upon reentry (up to one year). **Inclusion Criteria:** Physical health, BH, or SDOH need that places the enrollee at risk for readmission; institutionalization/unnecessary ED visits within the last six months
Goal	Prevent institutionalization/adverse outcomes; meet care goals, self-management, and SDOH needs; reduce barriers to care and disease burden
Objective	No unplanned inpatient admission/unnecessary ED visit within last six months
Supports	In-person HNA/ comprehensive/home assessment /Plan of Care within 30 days of identification of physical health, BH, and SDOH need; monthly ICT/Case Manager-led CM meetings, or as Plan of Care requires in enrollee's preferred setting; CHW/Peer Support Specialist assistance; in-person Plan of Care update (at minimum) quarterly, upon condition change, enrollee/ICT member request, and monthly attestation to PCP/enrollee
Transitional CM: Enrollees Who Are Transitioning Between Levels of Care or Reentering the Community	
Profile	Enrollees moving between care settings: to/from inpatient hospitals, nursing facilities (not including Members of the Department of Justice (DOJ) Agreement Target Population), psychiatric residential treatment facilities (PRTF), therapeutic group homes (TGH), intermediate care facility for individuals with intellectual disabilities (ICF/IID), residential SUD treatment, incarceration, and permanent supportive housing
Goal	Transition between settings or levels of care without potentially preventable events (PPEs) occurring
Objective	No unplanned inpatient admission/unnecessary ED visit for six months
Supports	Service Coordination between settings of care; short-/long-term hospital and institutional stay discharge planning; PRTF, TGH, or ICF/IID discharge; and aftercare service 30 days prior to discharge. Case Manager provides a transition Plan of Care with enrollee's care setting; Enrollee/key ICT members prior to transition; and written enrollee discharge notice with post discharge care appointments, linkages to CBO/SDOH support, medication reconciliation, self-management strategies and education, and prior authorizations. The Case Manager shares contact information with enrollee prior to discharge, confirms transition setting shares treatment information with the PCP and BH providers; follows-up with enrollees within seven calendar days after discharge/transition; ensures Plan of Care services are provided; identifies necessary circumstances in Plan of Care for face-to-face and additional follow-up in the enrollee's discharge plan; coordinates across the ICT involved in transitional CM

Addressing Homelessness: We offer a [redacted]

Specialized Supports: We are providing a specialized community CM program, consistent with the **DOJ Agreement and LDH-issued guidance** for enrollees who are transitioning or who have been diverted from a nursing facility level of care. We use subcontracted community Case Managers who meet LDH established qualifications to refer enrollees to a community CM agency within one business day of

receipt of an LDH referral. We maintain ultimate responsibility for the community Case Manager's satisfactory completion of required activities, meeting the enrollee's CM needs.

Integrated and Specialty Assessments to Determine Level of Services Needed

We recognize the complexity of Medicaid enrollees' health needs through our experience serving other Medicaid enrollees, and we use that experience to develop our comprehensive and specialty assessments to review physical health, BH, and SDOH needs. In compliance with **Model Contract Section 2.7.3**, we will complete a comprehensive assessment for at least 90% of enrollees identified with SHCN, whom we have been able to contact, and who are willing to engage, within 90 calendar days of identification of having SHCN. We have learned that enrollee engagement and permission is vital for acquiring information and driving health outcomes, which is why we train our CM team extensively in motivational interviewing, person-centered care planning, mental health first aid, trauma-informed care, and cultural sensitivity. This inclusive training provides the tools and techniques our Case Managers need to work with enrollees, or their representative, to gather often sensitive information and drive active participation with our enrollees. **As of March 2021, 99.2% of our Illinois Medicare Medicaid Alignment Initiative assessments were completed within 90 days, with those enrollees we could reach, and 100% of those enrollees completed a Plan of Care within in 90 days.**

Integrated Care Team: Our Case Managers work closely with their assigned enrollees to identify additional care partners and obtain the enrollee's permission for those partners to become part of their ICT, which can include the enrollee's PCP, BH, and other specialists, and caregivers, a Housing Specialist, a pharmacist, and other internal Humana resources, as well as CBOs. The Case Manager leads the ICT, with the enrollee or their representative closely involved, to identify and prioritize the Plan of Care's SMART goals. The SMART goals outline the enrollee's objectives and timeline for completion. Our **Integration+** platform captures the enrollee's assessment answers and goals and informs the person-centered Plan of Care. The ICT can include CHWs and CBOs to address the individual's SDOH concerns. With the enrollee's permission the Case Manager shares the Plan of Care with the other ICT members. Our Case Managers leverage our strong partnerships with network providers, State agencies, and CBOs to meet each enrollee's individual needs. We recognize that many of our enrollees with complex needs, including those with serious mental illness (SMI), often have strong, established relationships with their physical health and BH providers. To avoid disrupting these relationships, we have designed our CM structure to incorporate and support the enrollee's existing CM services through robust data sharing via our provider portal, streamlined provider communication, and regular ICT meetings. When the enrollee's PCP or BH provider is acting as the Case Manager lead on the ICT, we will identify them as the Case Manager and include anyone the enrollee identifies and requests in the ICT meetings.

Assessing Enrollee's Need for Nursing Facility: Humana's person-centered approach to evaluate enrollees with SMI reflects the individual's current functional status, incorporating current evaluative data obtained prior to initiation of PASRR. Our established policies and procedures fully comply with **Model Contract Section 2.7.7** and the LA Department of Justice (DOJ) Agreement and ensure enrollees are not inappropriately placed in nursing homes for long-term care. We complete Level II determinations within four calendar days of Office of Behavioral Health (OBH) referral to confirm if the individual has a SMI and specifies the services and supports necessary to live successfully in the community. We will ensure all individuals who apply for nursing facility services are given information about community options, and when LDH determines that nursing facility services are inappropriate, we will assist eligible enrollees in obtaining the appropriate alternative BH services available under this Contract. If at any time we identify or become aware of an enrollee with SMI, residing in a nursing home without a Level II determination, we will notify LDH and conduct the evaluation. If we identify the need to supplement or verify the accuracy and timeliness of the enrollee's data, we will assess their documentation and evaluation data for proper placement and treatment. For those enrollees without sufficient documentation to establish a valid primary dementia diagnosis, we authorize additional professional evaluations to ensure appropriate diagnosis and differentiation.

Assessing Enrollee's Need for Specialized BH Services: Humana will ensure **PASRR Level I evaluations** are completed and all enrollees presenting with a SMI history or symptoms are evaluated for the correct treatment in the appropriate setting. **Our LMHPs will complete a PASRR Level II in person for all enrollees within four calendar days of notification of a positive PASRR Level I**, excluding those enrollees with a developmental disability. We initiate all screenings and Level II evaluations presuming that the enrollee can live in a

community-based residence and that their Plan of Care recommendations focus on providing the most appropriate level of care in the least restrictive setting. Upon completion, Level II evaluations are stored in our **Integration+** platform and submitted to the OBH. If OBH determines nursing facility services are inappropriate, we help enrollees obtain alternative BH services that are available under this Contract.

The Process for Developing an Individual Plan of Care

In our **individualized person-centered, enrollee-driven Plan of Care process**, our Case Manager works with the enrollee to identify participants for the ICT. The ICT includes the enrollee, Case Manager and PCP as well as additional supports. With the comprehensive assessment as a basis, the enrollee's Plan of Care identifies physical, environmental, BH, and SDOH services and supports to achieve short-and long-term goals, strengthen self-management, and move along the care continuum toward improved health. The Case Manager completes the Plan of Care in real time with the enrollee, using our Integration+ platform to deliver efficient coordination of covered services in the Plan of Care. Recognizing the varied linguistic needs of our non-English speaking and nonverbal enrollees, we accommodate their communication needs in their Plan of Care. If a bilingual Case Manager is not available, an interpreter will participate in all enrollee interactions. Our Concierge Service for Accessibility assists our visually or hearing-impaired enrollees, arranging TTY, braille, or other translation interventions that facilitate full engagement in the CM and Plan of Care development process. We complete Tier 2 and Tier 3 Plans of Care in 30 days, and Tier 1 Plans of Care in 90 days—the enrollee and their representative can access via the enrollee portal, or is given a printed copy, which we translate, upon request. The enrollee's providers, including their PCP and BH provider, access the Plan of Care via our provider portal. The Case Manager completes attestations and monthly, quarterly, or annual Plan of Care updates, per the Contract, and reviews the enrollee's progress in ICT meetings, modifying services as their needs change.

When we identify an enrollee receiving CM from a provider or a State agency, with the enrollee's permission our Case Manager will introduce themselves to the provider or State agency case manager to discuss next steps, including the next ICT meeting; and invite the provider or State case manager to join the ICT. We will coordinate with the enrollee's providers or agency staff to develop the enrollee's Plan of Care and coordinate processes and procedures that are amenable to all parties. We simplify the process for the enrollee by reducing the number of contact points while preventing duplicative services. Our Case Manager will provide the provider or agency a direct telephone number to the enrollee's CM team, a shared email inbox to transmit information and send queries; and share the Plan of Care upon request. If the enrollee has another Plan of Care, we will include the network provider or State case manager in discharge planning, coordination of healthcare and SDOH services, and follow-up appointments.

2.6.6.6 Establishing a Delegated Case Management Program

Humana has reviewed and confirms adherence to requirements in **Model Contract Part 2 Section 2.7.15 Delegated Case Management.** Our delegated Case Management program's goal and intent are to leverage existing provider capabilities and relationships to improve enrollee engagement and retention while reducing abrasion. We work to avoid disruption of care for enrollees who are accustomed to receiving CM and healthcare services from their current provider. We also strive to prevent duplication of services that could occur when multiple case managers communicate with the enrollee. Our CM team monitors and provides oversight to ensure we meet all Case Management requirements. We will use our Medicaid and Medicare experience, gained through delegated services in our other markets, to customize and deploy a Case Management delegation program in Louisiana.

Identifying and Selecting Qualified Provider for Case Management Delegation: We include PCPs, OB/GYN, and BH providers with qualifications for and willingness to take on delegated Case Management services. When we assess the qualifications of a provider or provider group for each Tier of delegated Case Management, we look for key provider practice capabilities that support delegated Case Management. For each CM Tier, we will hold

the delegated Case Management provider to the same clinical best practices, supports, and quality standards we require Humana Case Managers to meet to ensure the best possible outcomes for our enrollees. While our value-based payment (VBP) Readiness Assessment and Population Health Guide were originally created for other purposes, these two tools help identify key capabilities and readiness for delegated Case Management, such as:

- **Organizational Structure**: Strong leadership, including a Case Management champion and compliance team
- **Designations**: Patient-Centered Medical Home (PCMH) or Health Home designation; willingness to integrate BH services, if not already integrated; and working toward or have NCQA Case Management designation
- **Staffing**: On-site clinical staff, dedicated to Case Management; RNs for medical Case Management, and LMHPs for BH Case Management
- **Effective Health Information Technology (HIT)**: Appropriate technology to support the use of HIT, including electronic medical records (EMRs) and health information exchange connectivity, and two-way data transmission to effectively manage the enrollee's Case Management needs.
- **Population Health Management**: Demonstrated ability to care for the most vulnerable enrollee populations whom they serve to meet LDH required Case Management program Contract requirements.

Our VBP programs complement our delegated Case Management program. Network providers who participate in our VBP models are often best suited for delegated Case Management because they are already in risk arrangements and/or serve targeted, vulnerable populations, such as those [redacted] They also have the capacity and infrastructure to meet the State's Contract requirements and Humana's clinical best practice guidelines. We work with providers interested in providing delegated Case Management to create a path toward delegation through the support of our practice transformation program. To help providers establish their delegated Case Management program we identify the enrollees who qualify for delegated Case Management based on their needs and align with the provider's capabilities and qualification.

[redacted]

Payment for Delegated Case Management Services: Humana's approach to delegated Case Management reimbursement establishes per member per month (PMPM) payment based on LDH's rate development commensurate with provider-specific qualifications and delegated population. As part of payment negotiation, we assess the operational costs for our in-house Case Management services, including staffing, training, IT infrastructure, and clinical oversight. The provider would also assess their expected Case Management staffing expenses. Once Humana and the delegated Case Management provider agree on the cost and reimbursement terms, we will identify and stratify the qualifying enrollees based on the appropriate CM Tier.

Monitoring and Oversight Procedures to Ensure Delegated CM Providers Meet Requirements:
Our Licensure and Business Partner Compliance team oversees delegated Case Management provider pre-assessment, approval, oversight, and monitoring to ensure the providers are meeting LDH's CM requirements. Our market-based CM and Quality Improvement teams work with and support delegated Case Management providers to confirm adherence to our quality standards and remediate any issues related to performance, enrollee satisfaction, or health outcomes. Delegation activities are reported annually through the Quality Improvement Committee who will provide continuous monitoring, oversight and reporting at the group, provider, and enrollee levels to address any needed support or interventions.

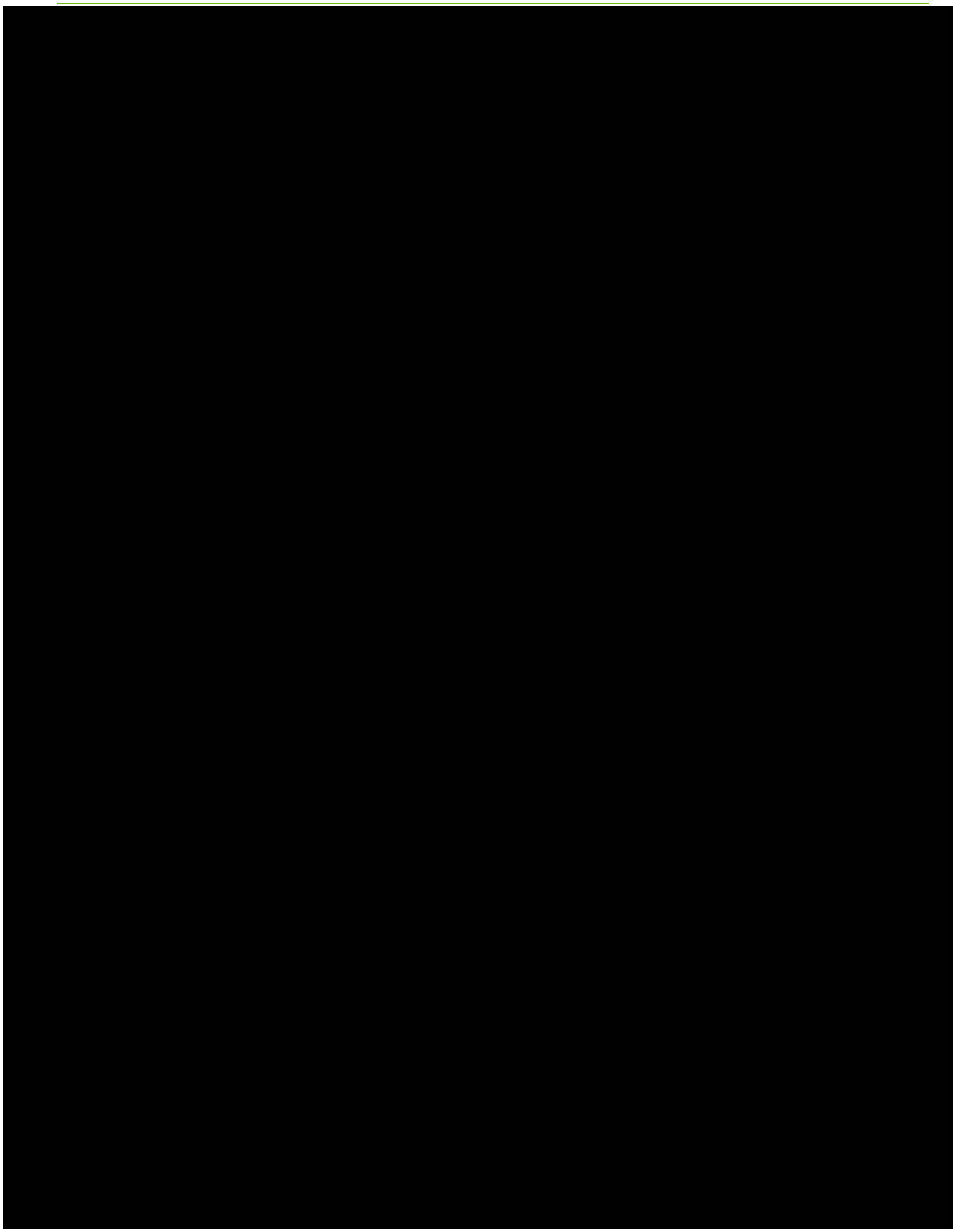
Young children thrive and learn through a variety of year-around, full-day academic and social enrichment activities at Kingsley House Head Start program. Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

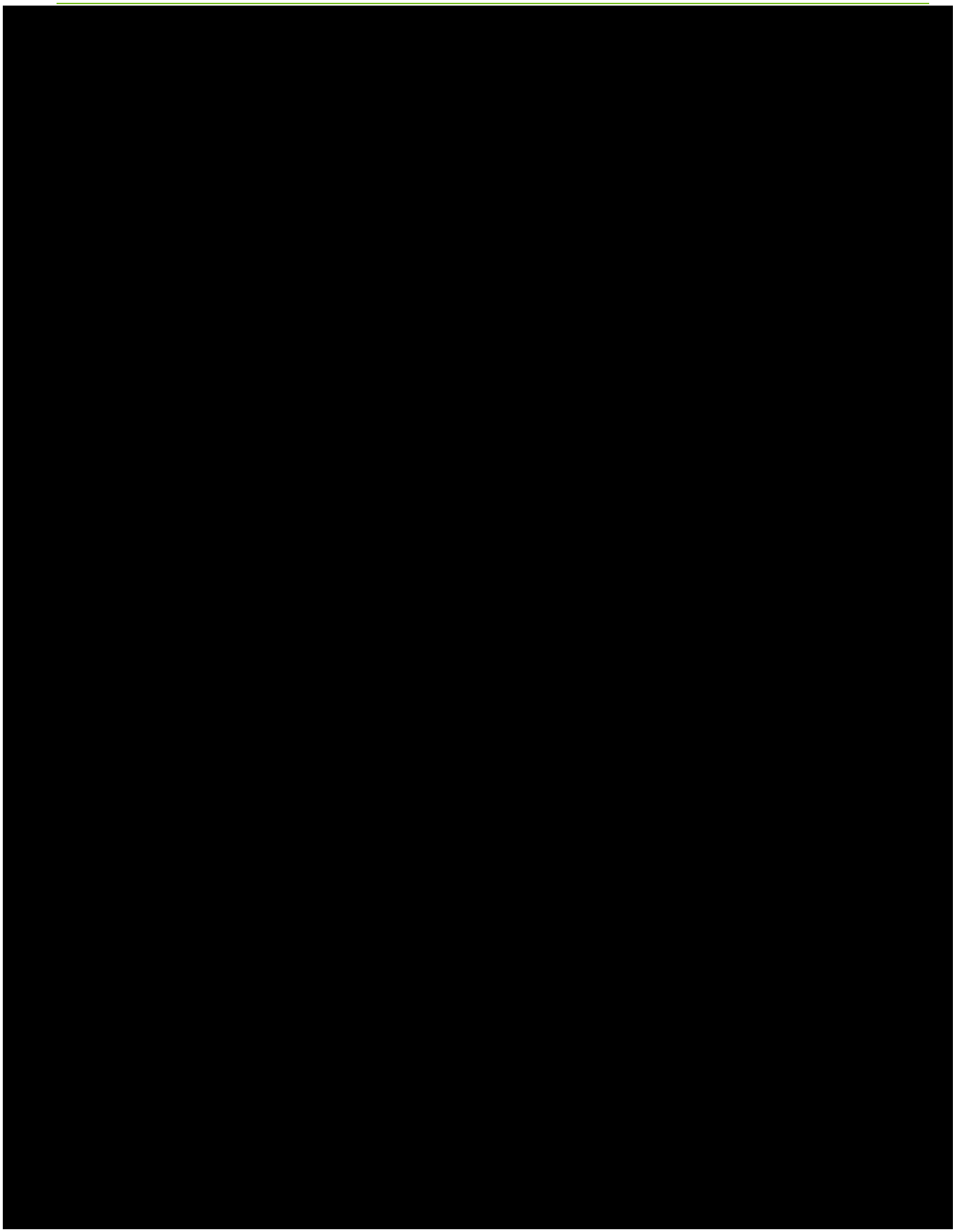
Section 2.6.7

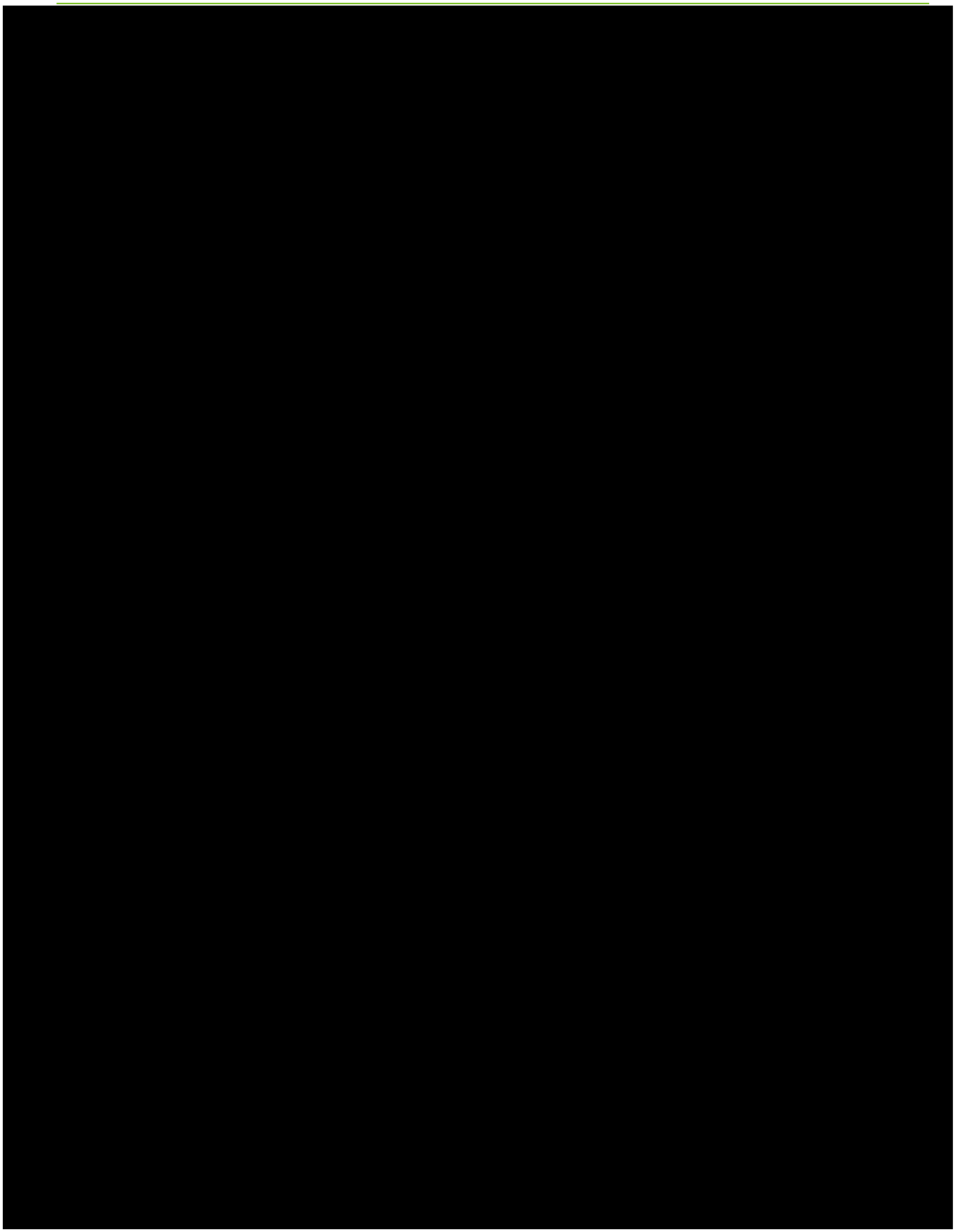
Case Scenarios

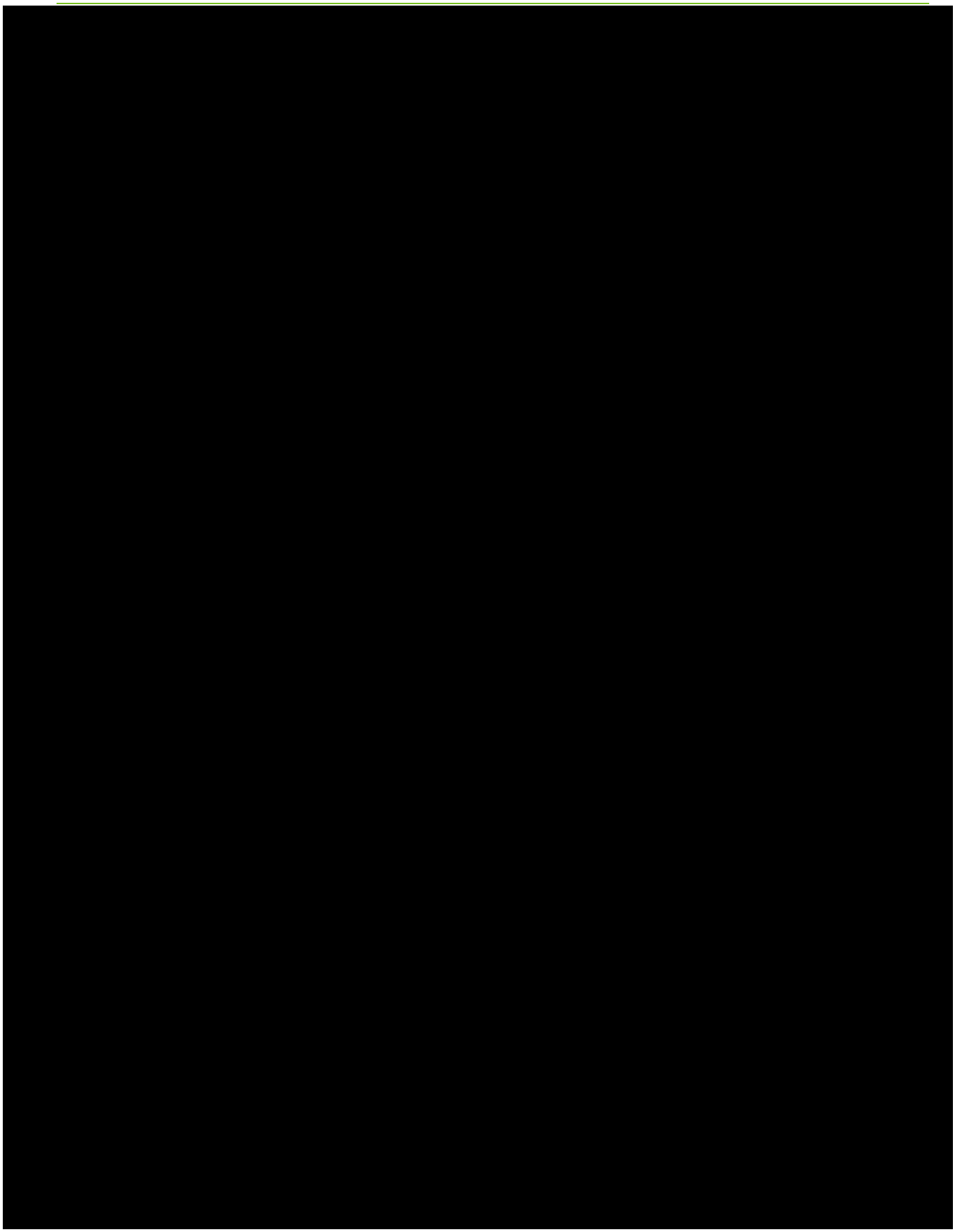
Humana

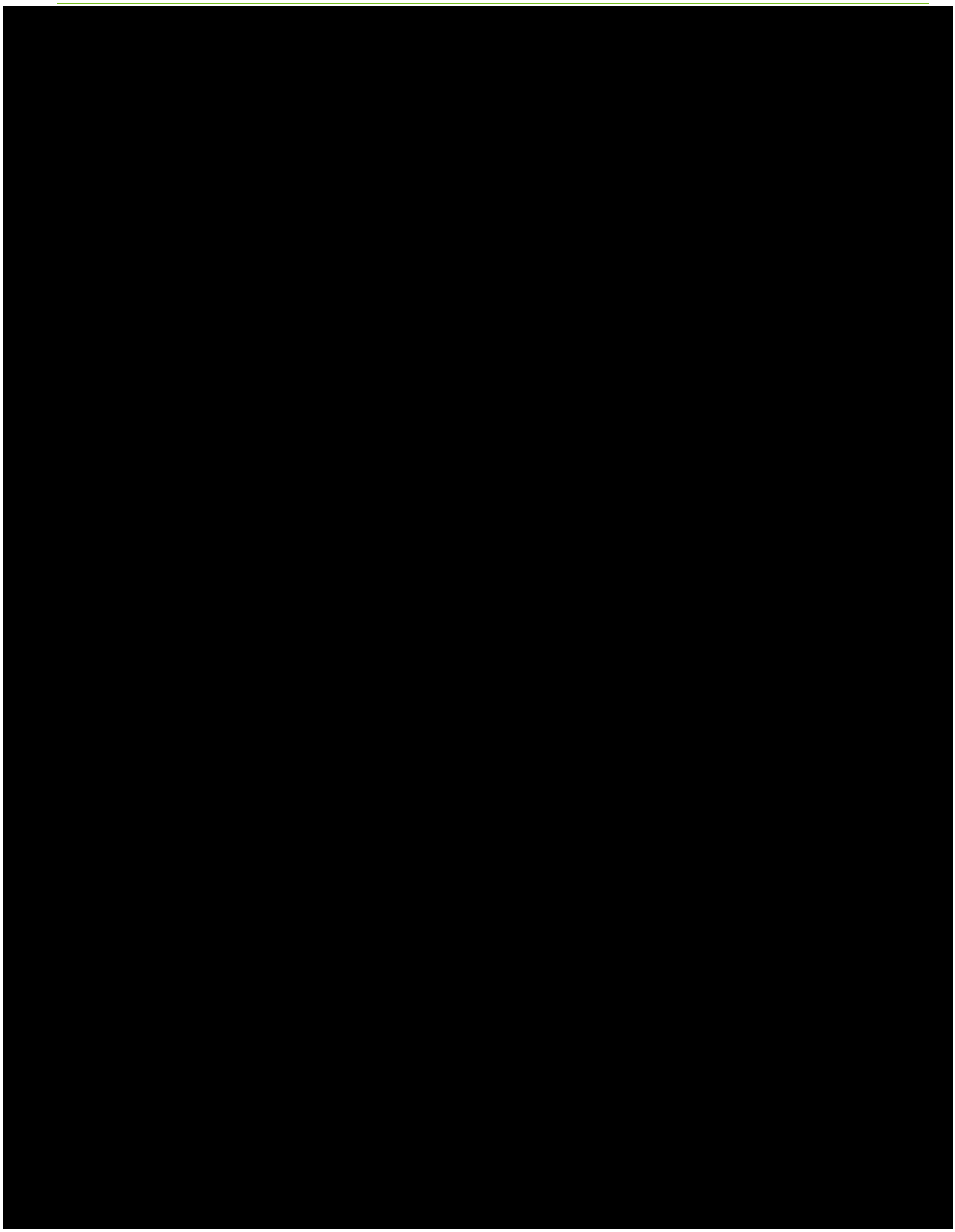
Healthy Horizons™
in Louisiana

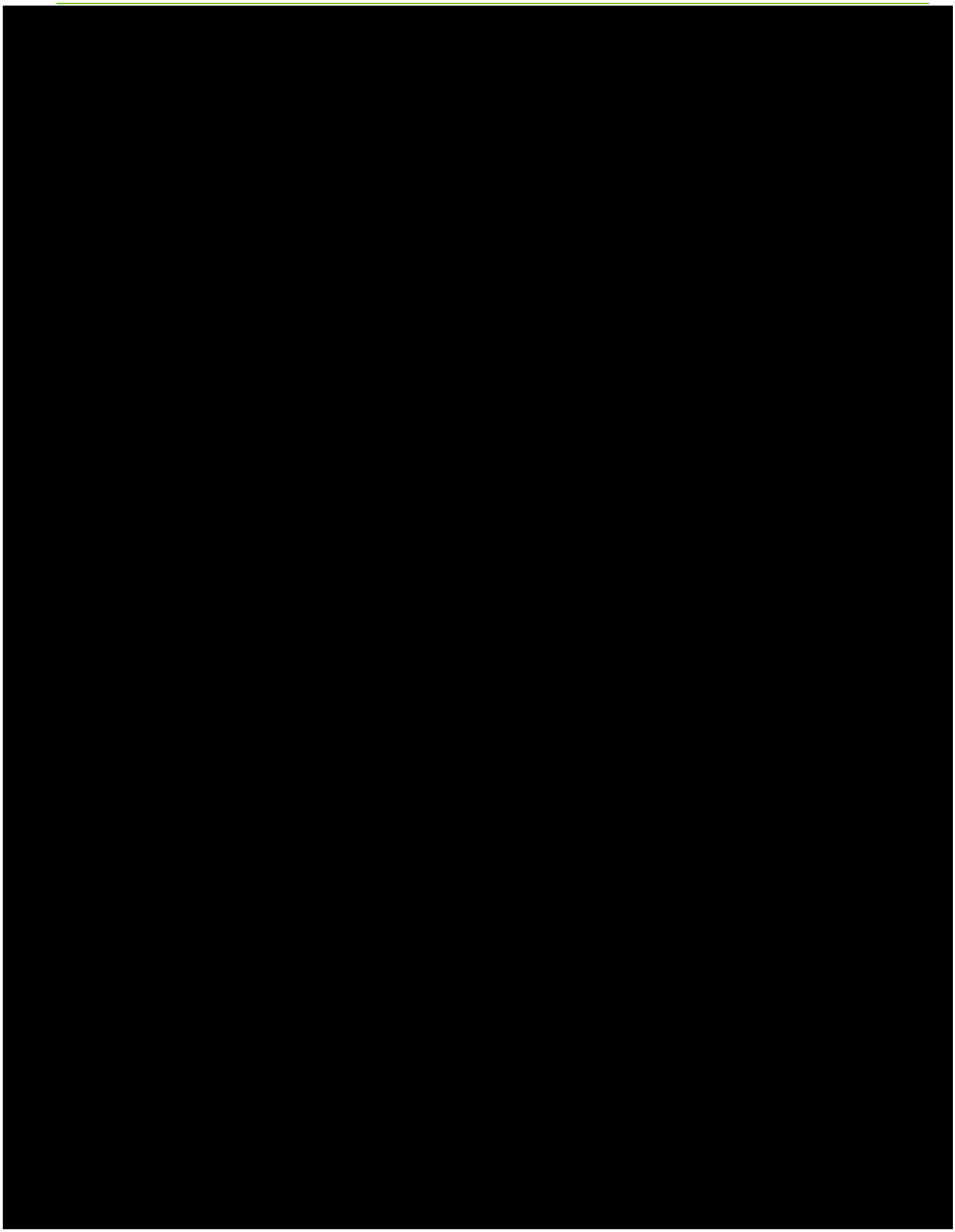


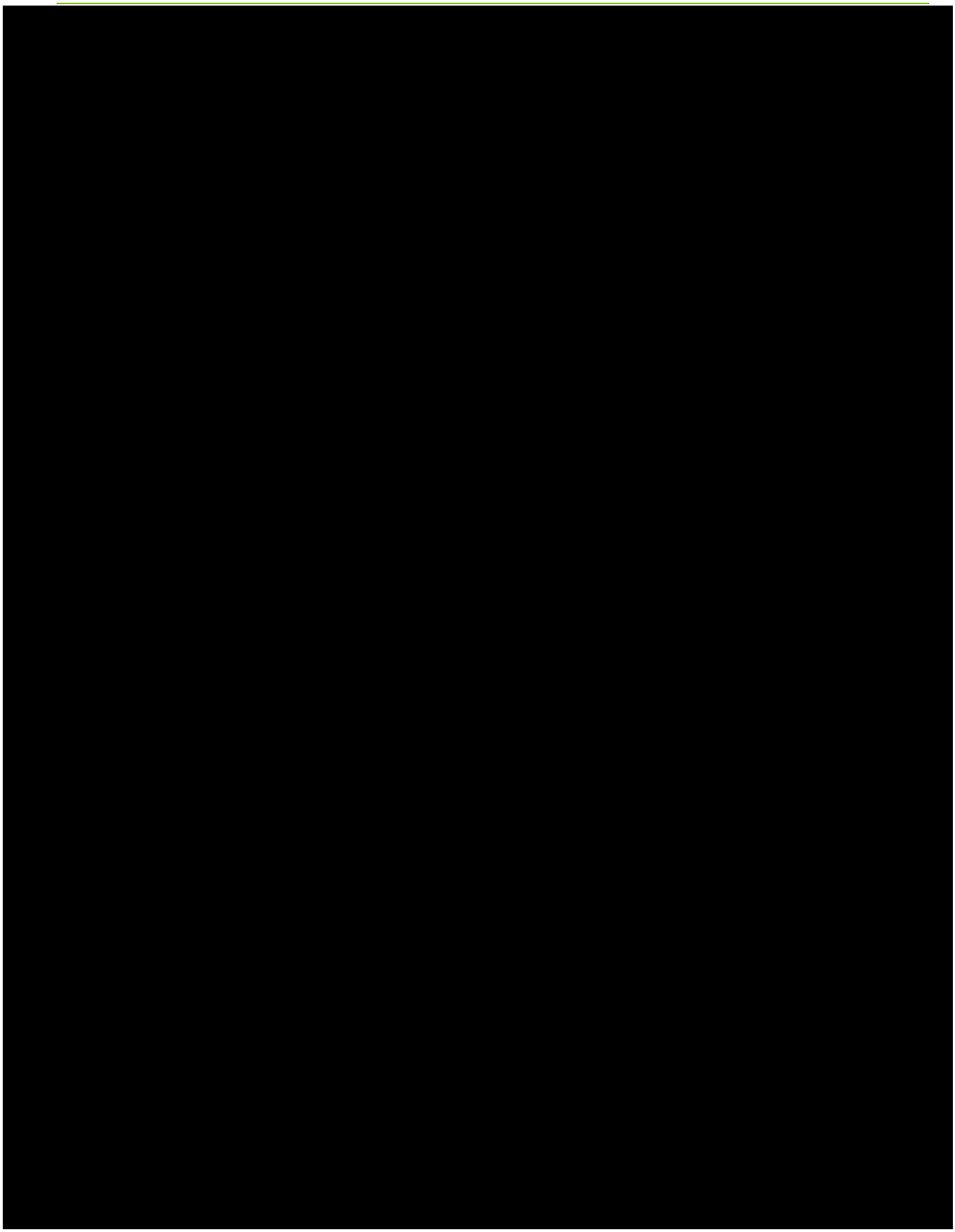


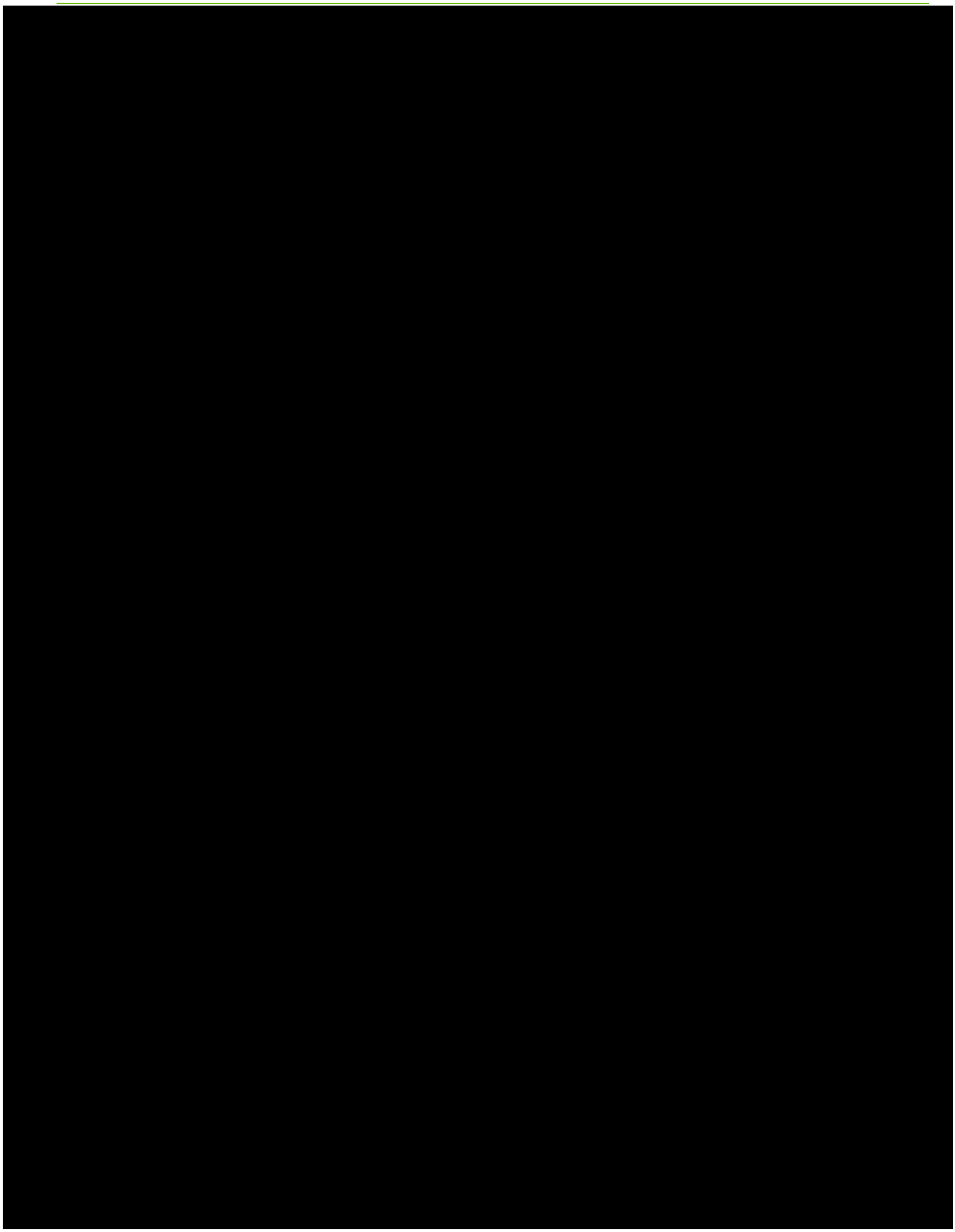


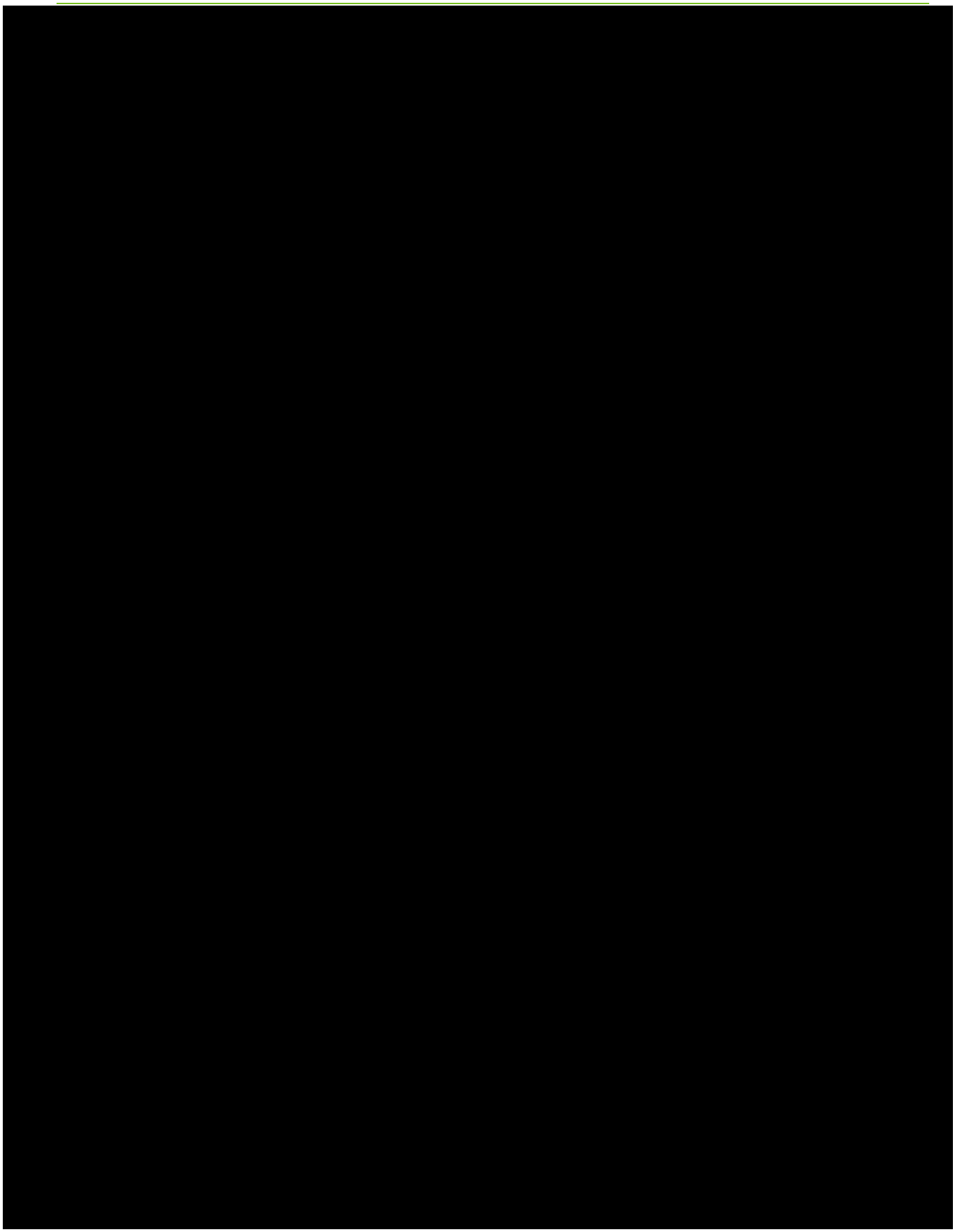


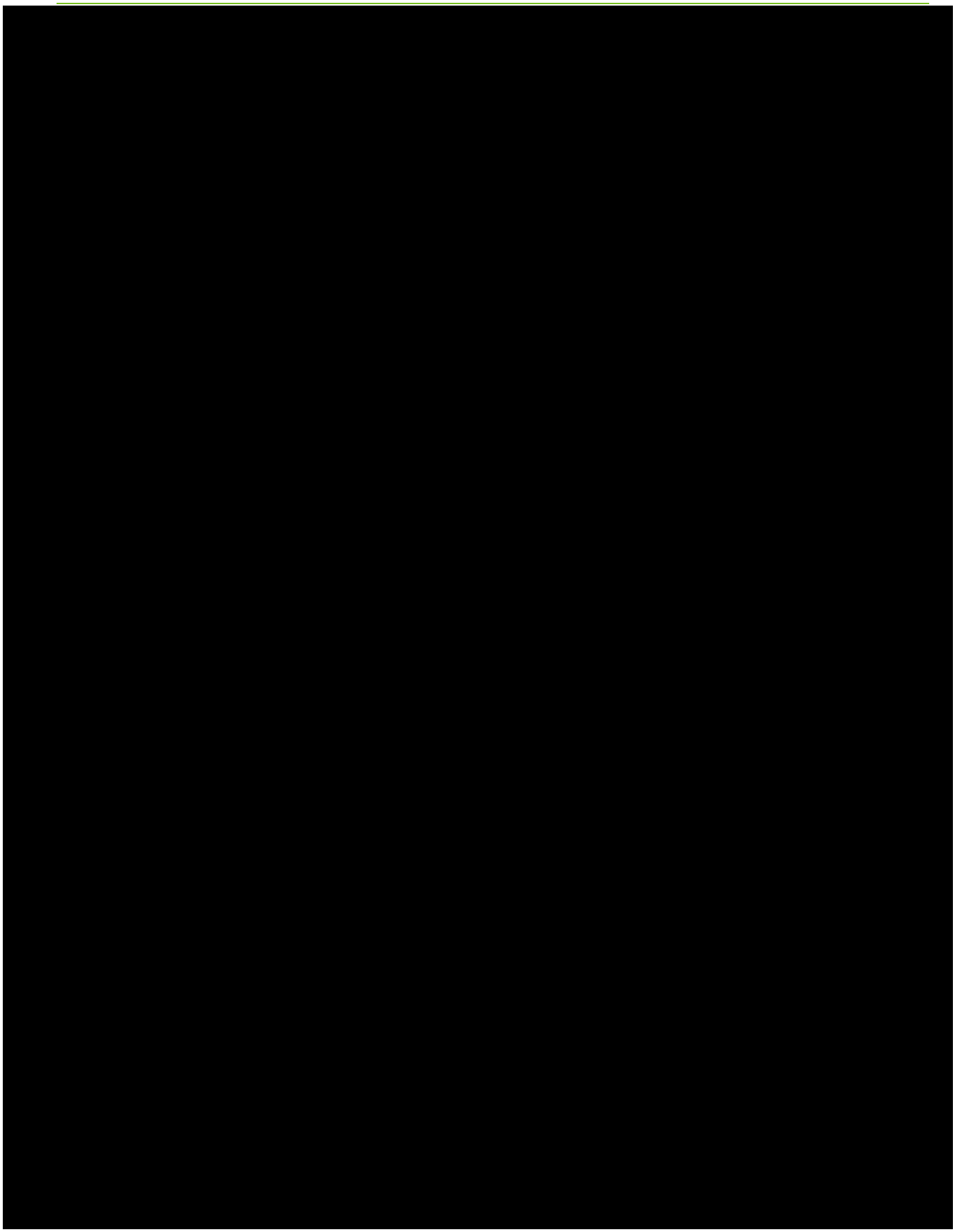


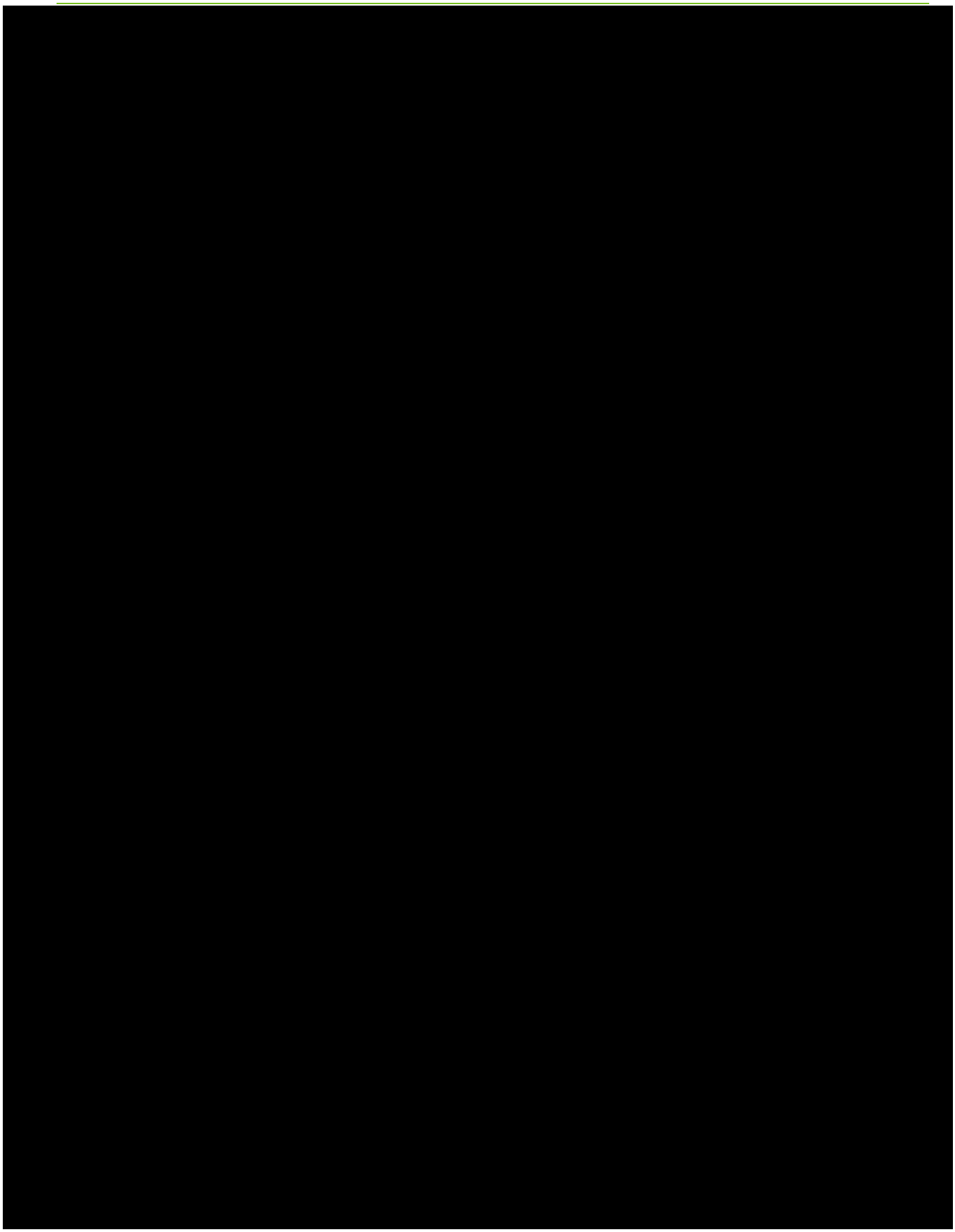


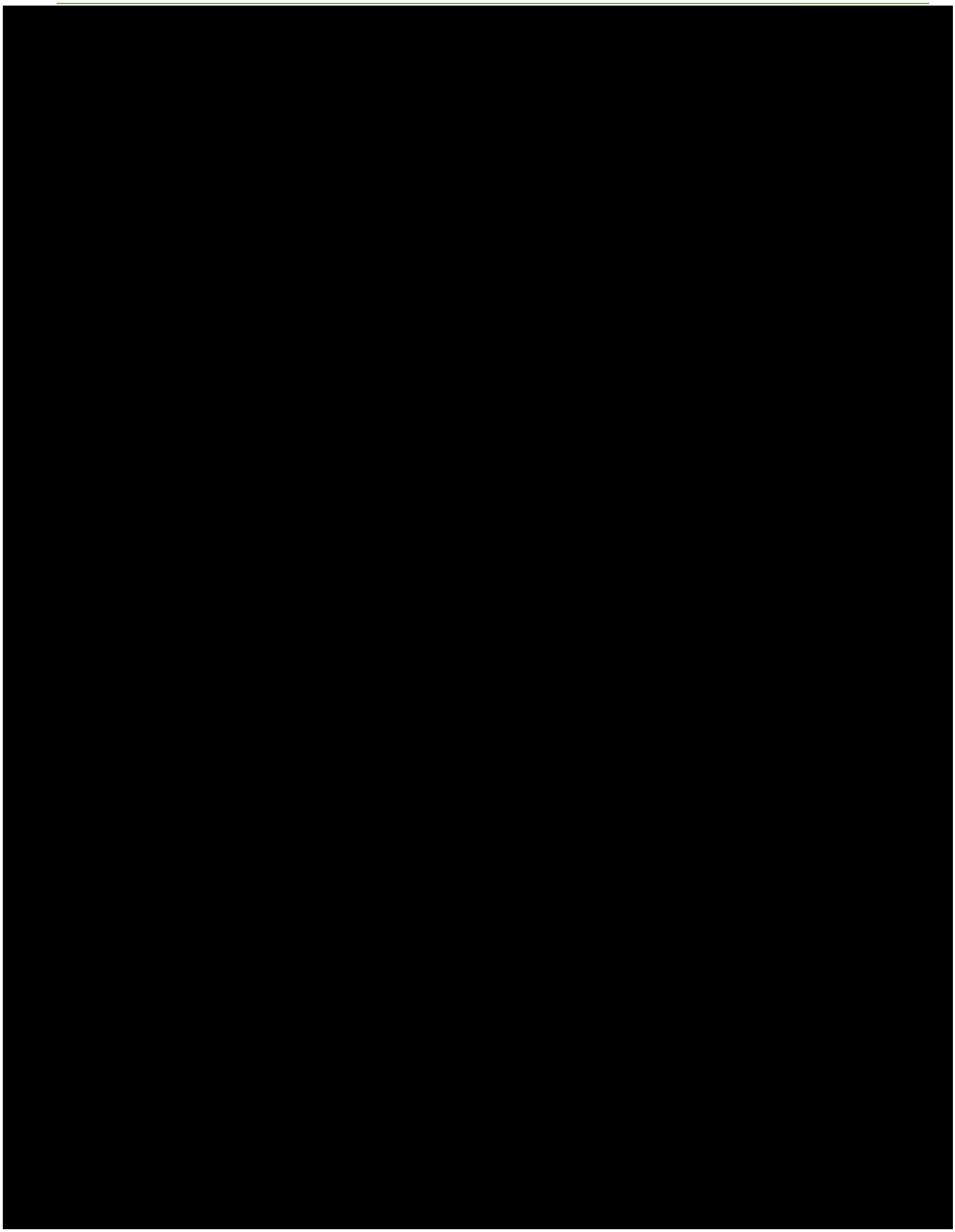


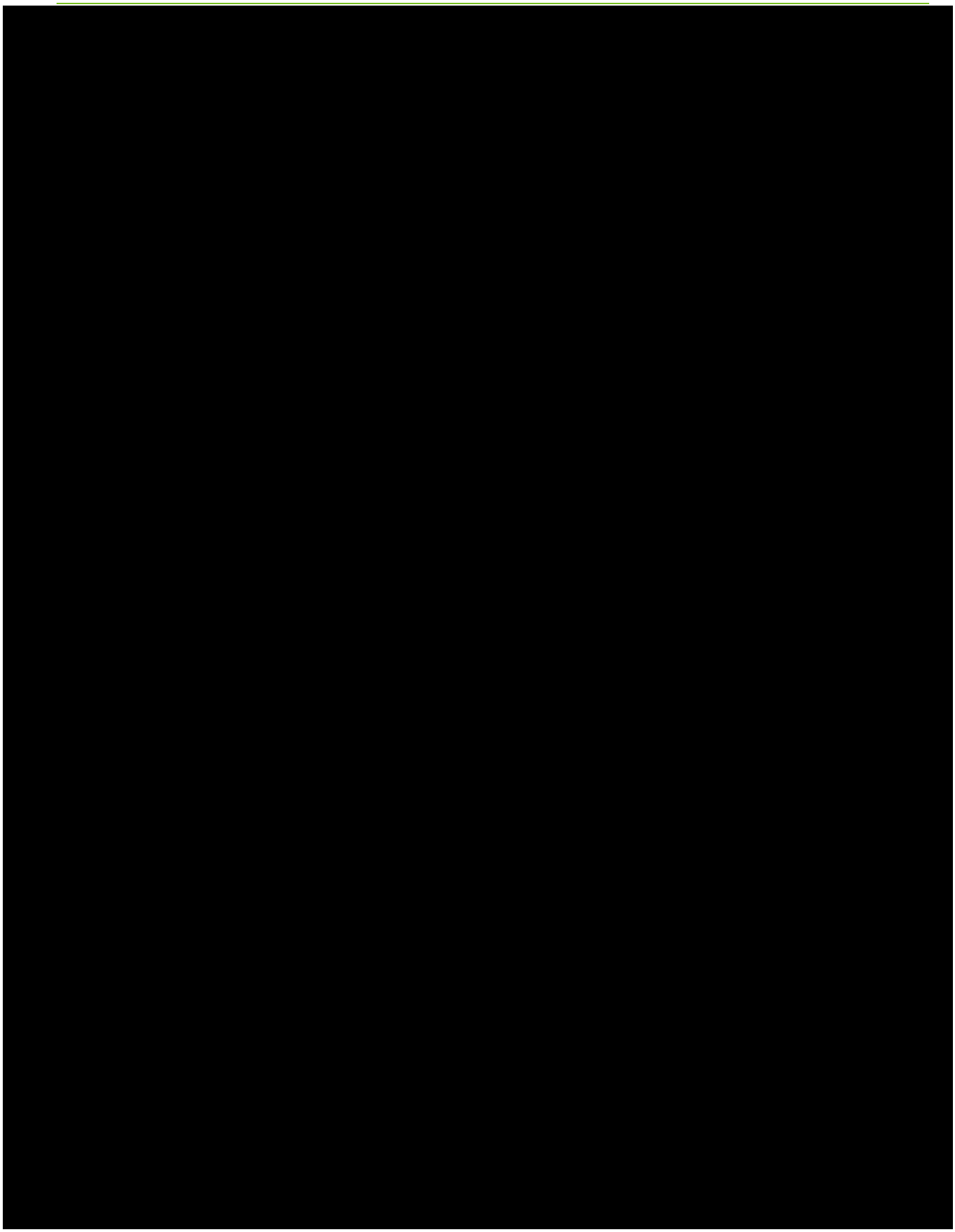


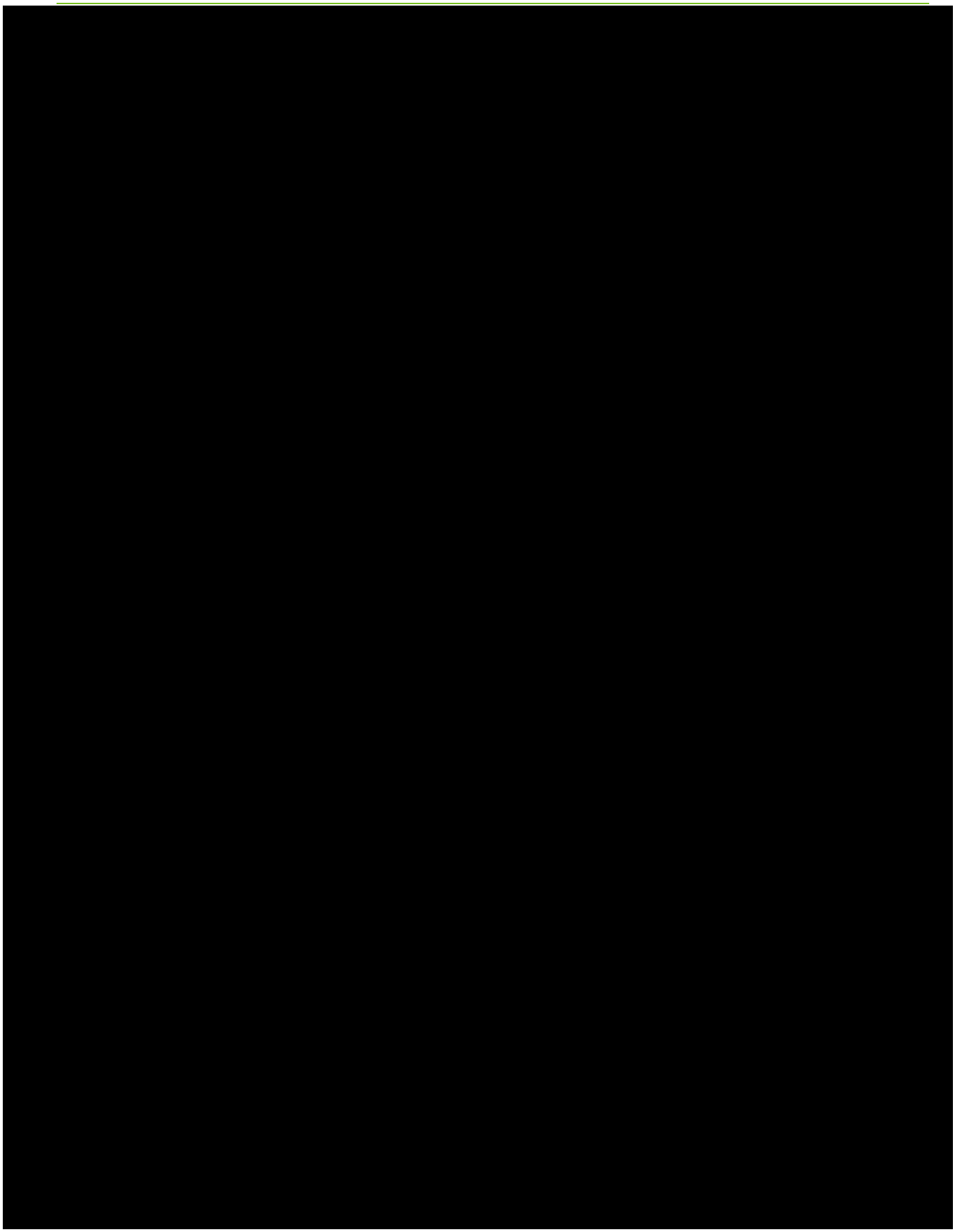


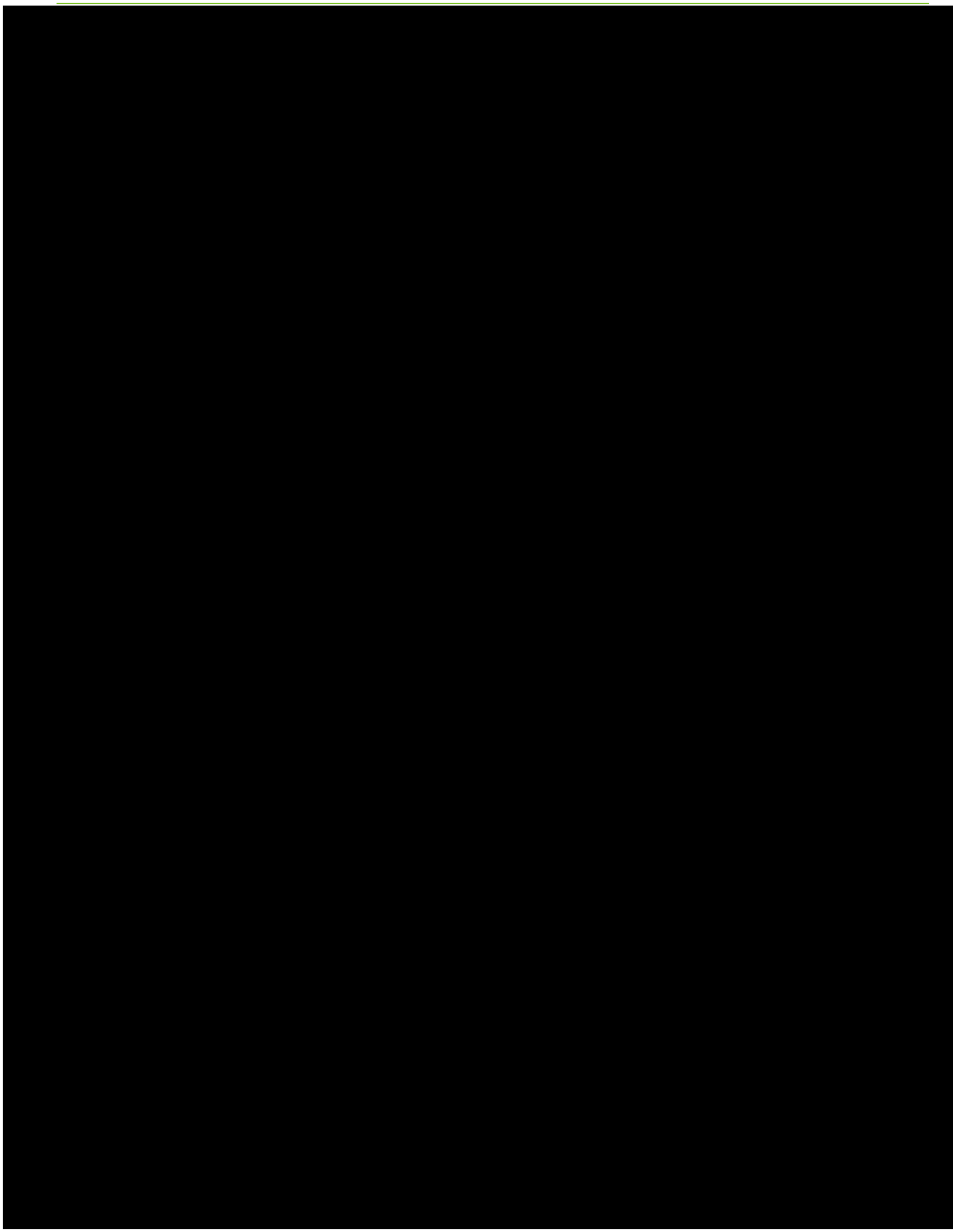


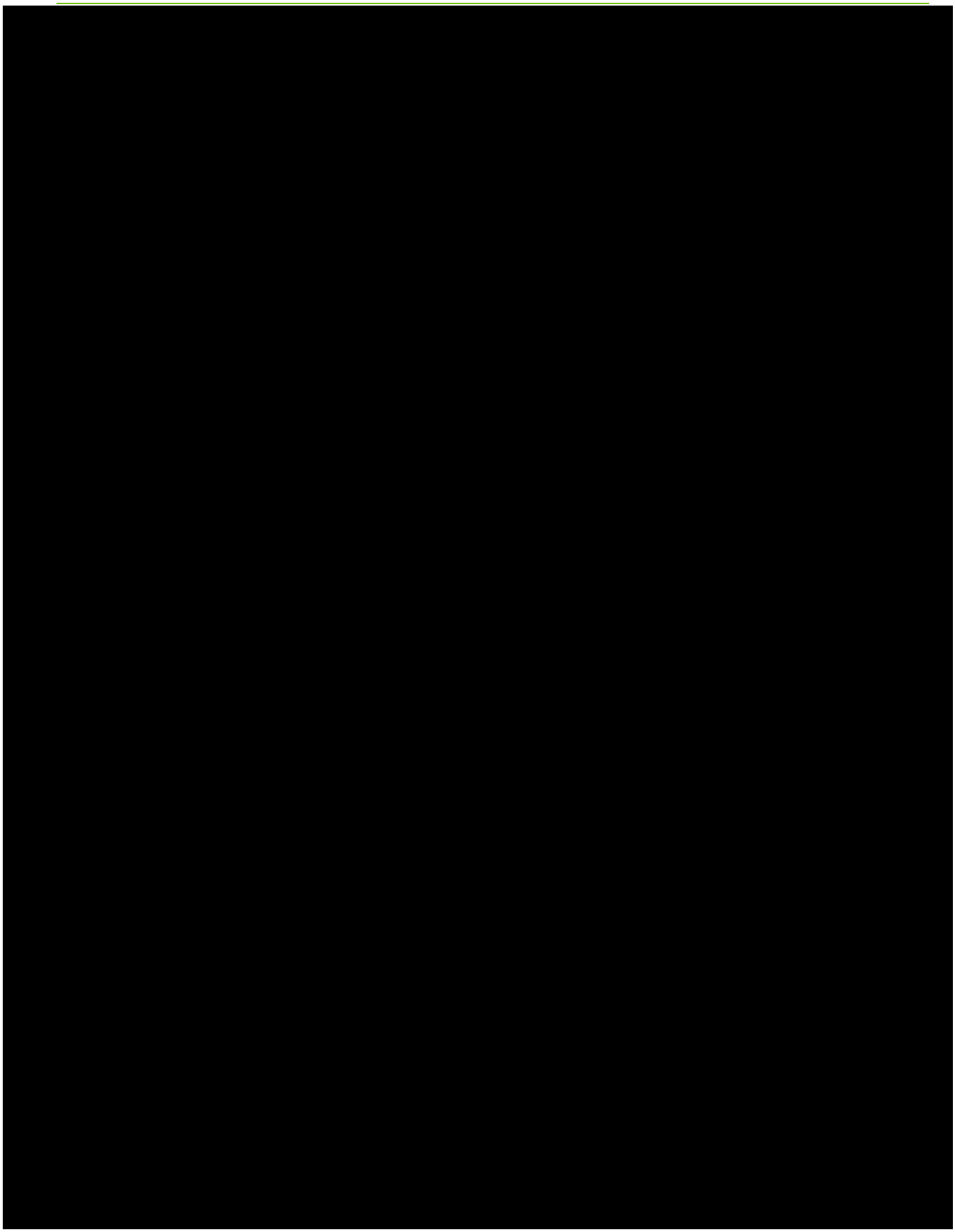


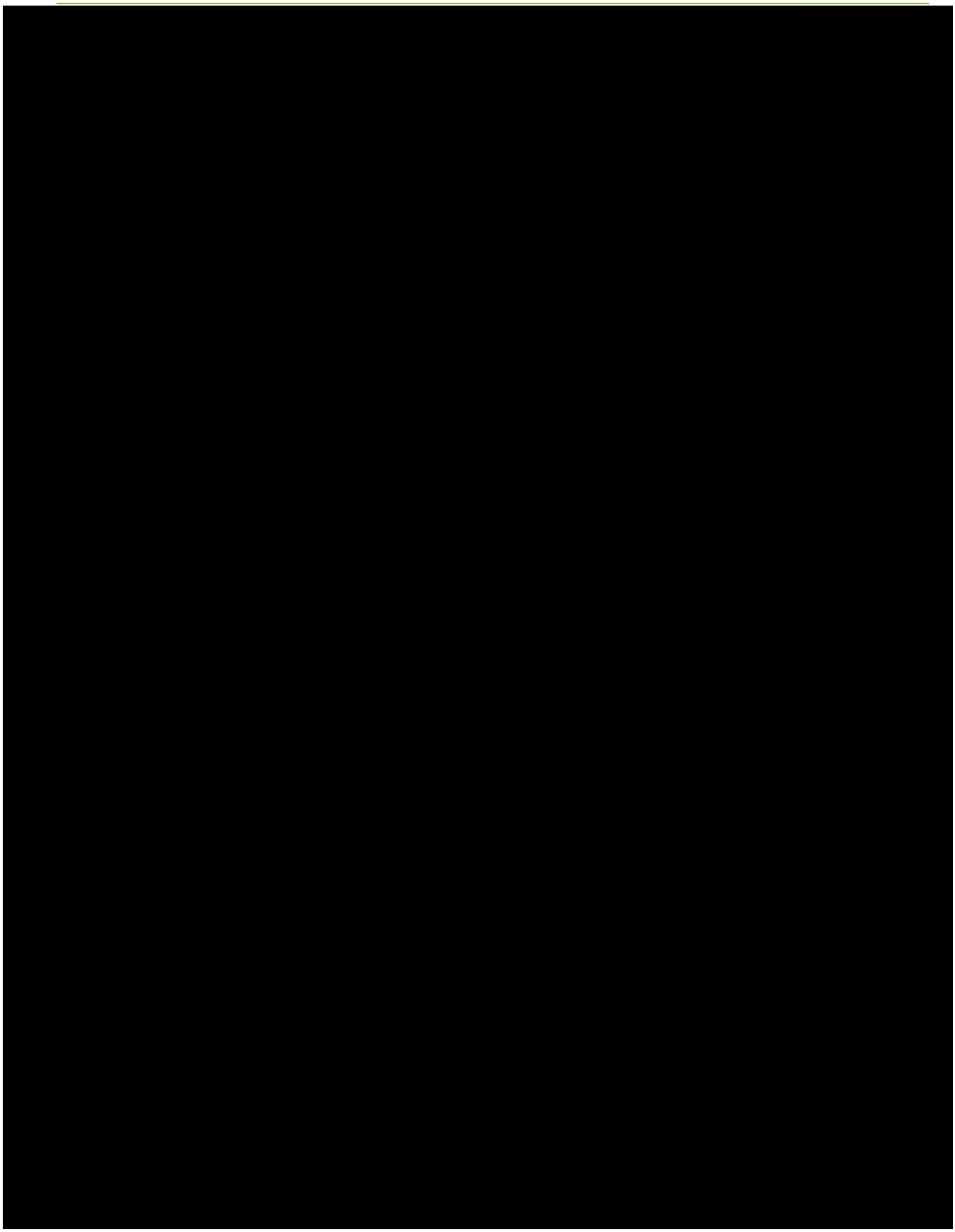


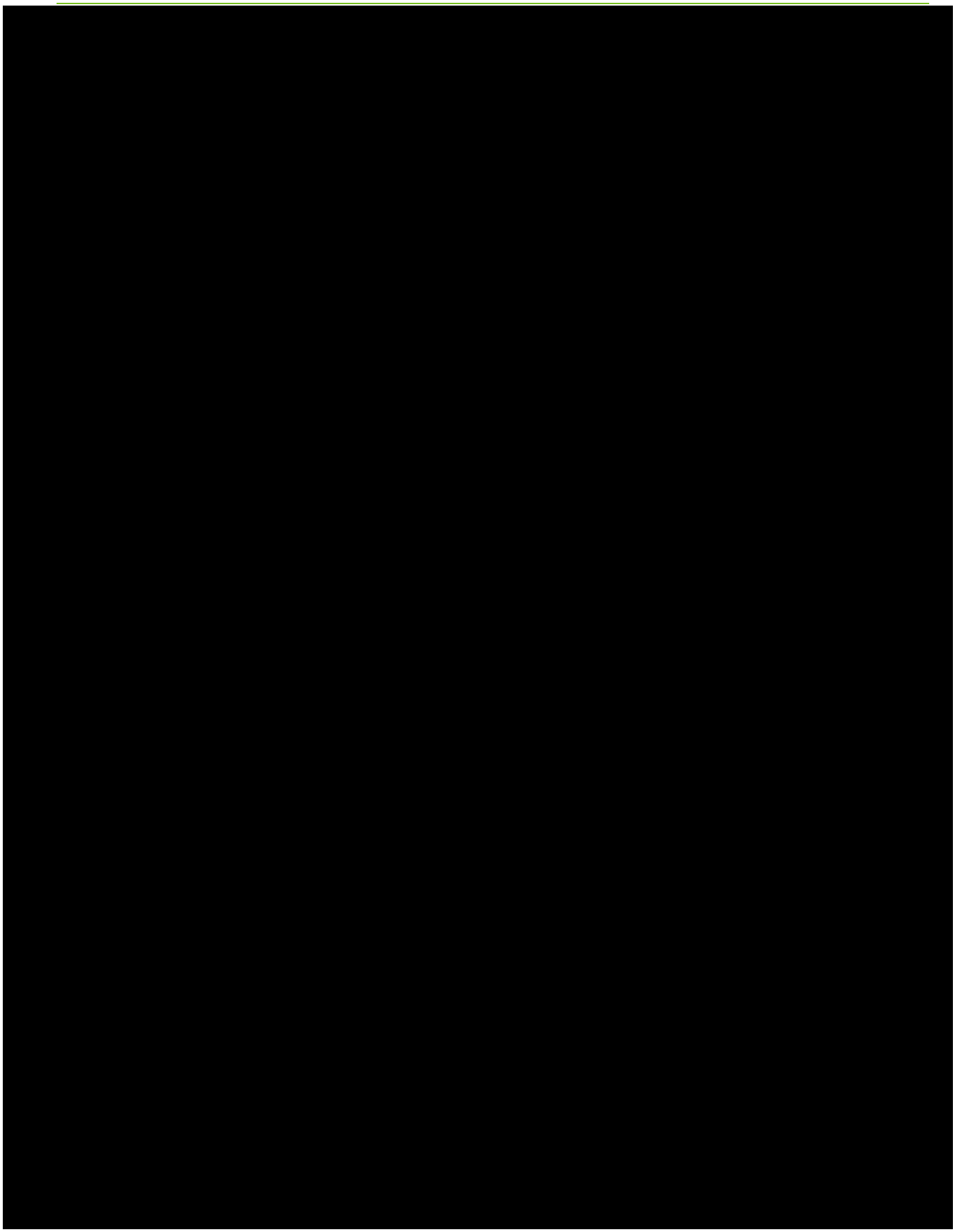


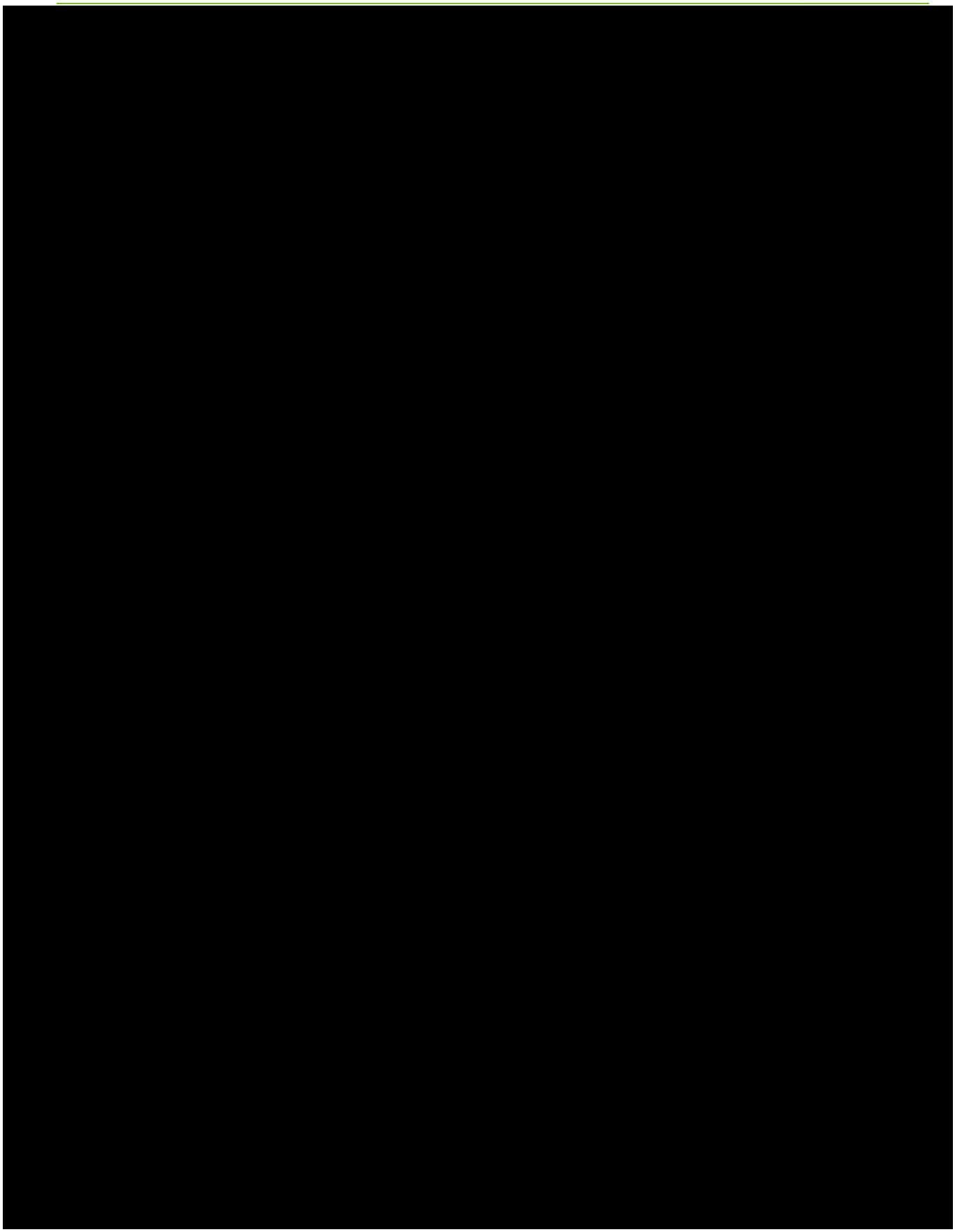


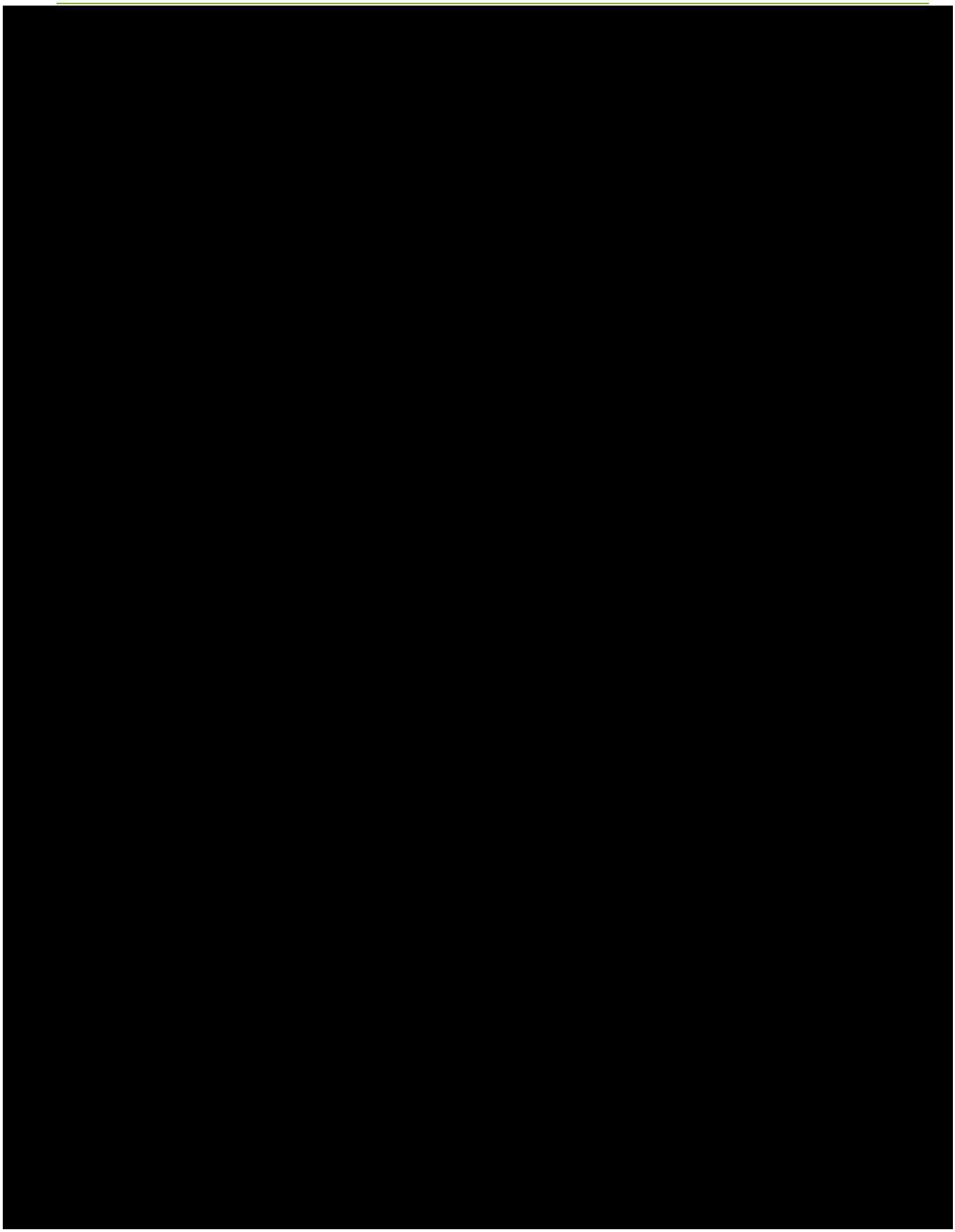


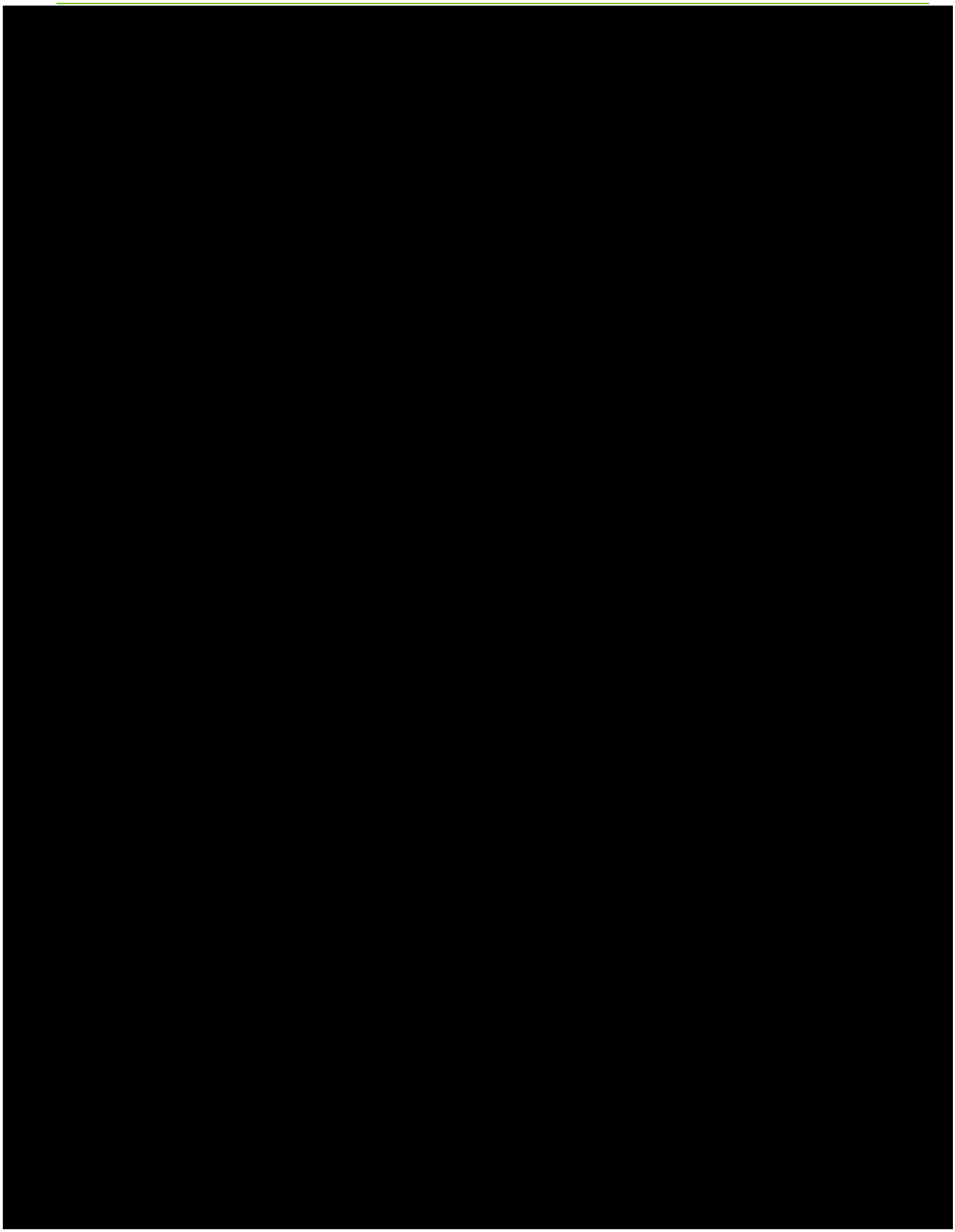


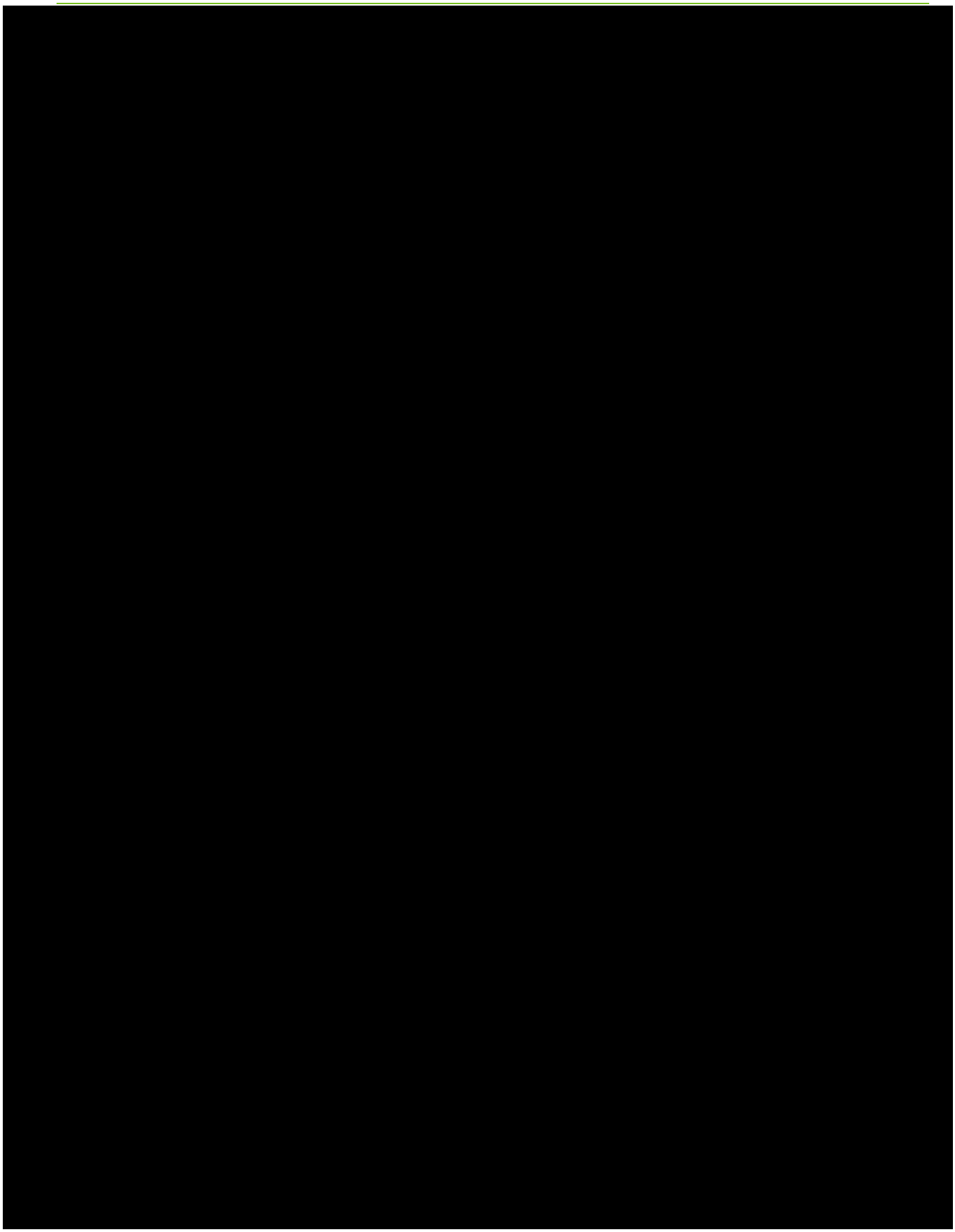


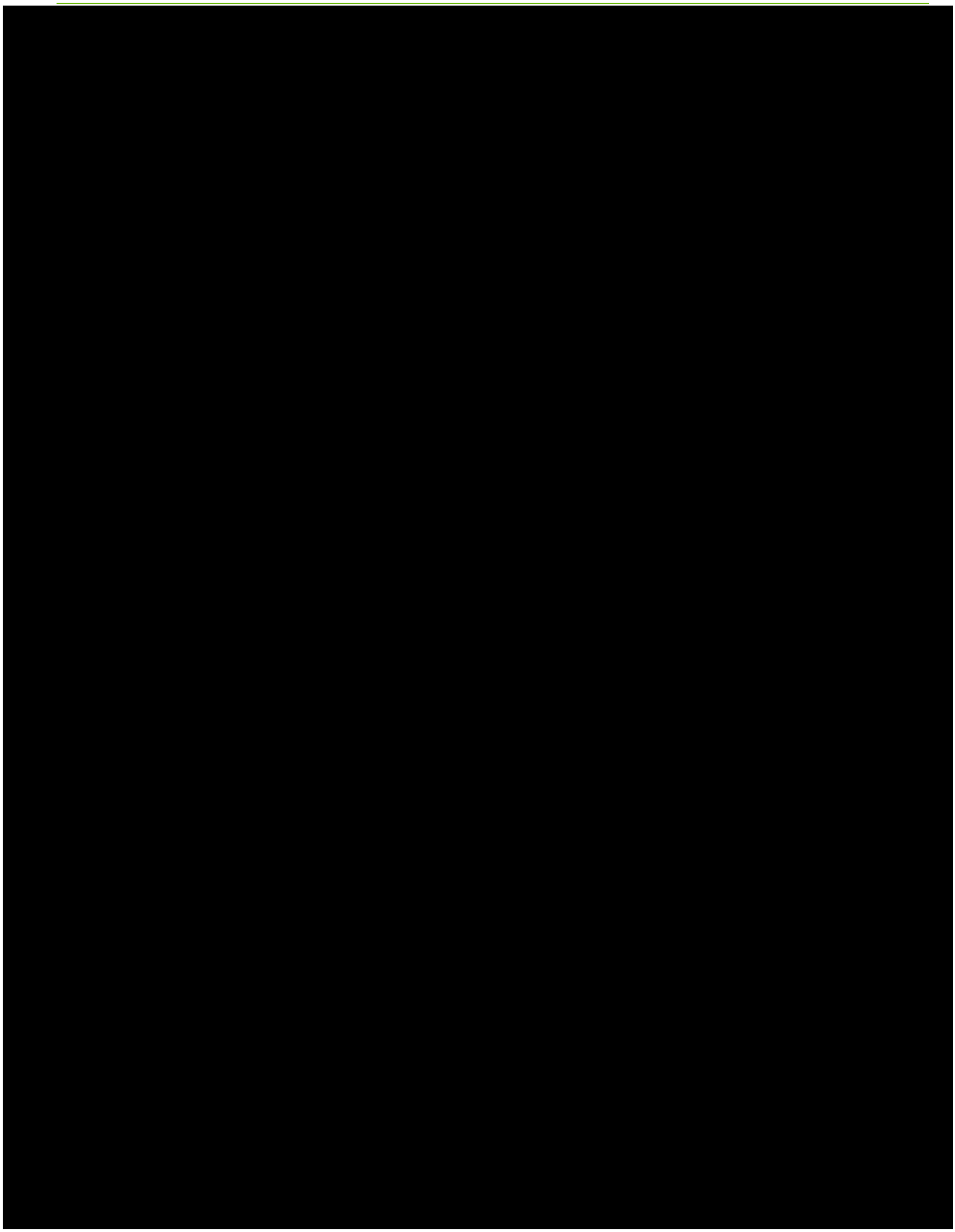


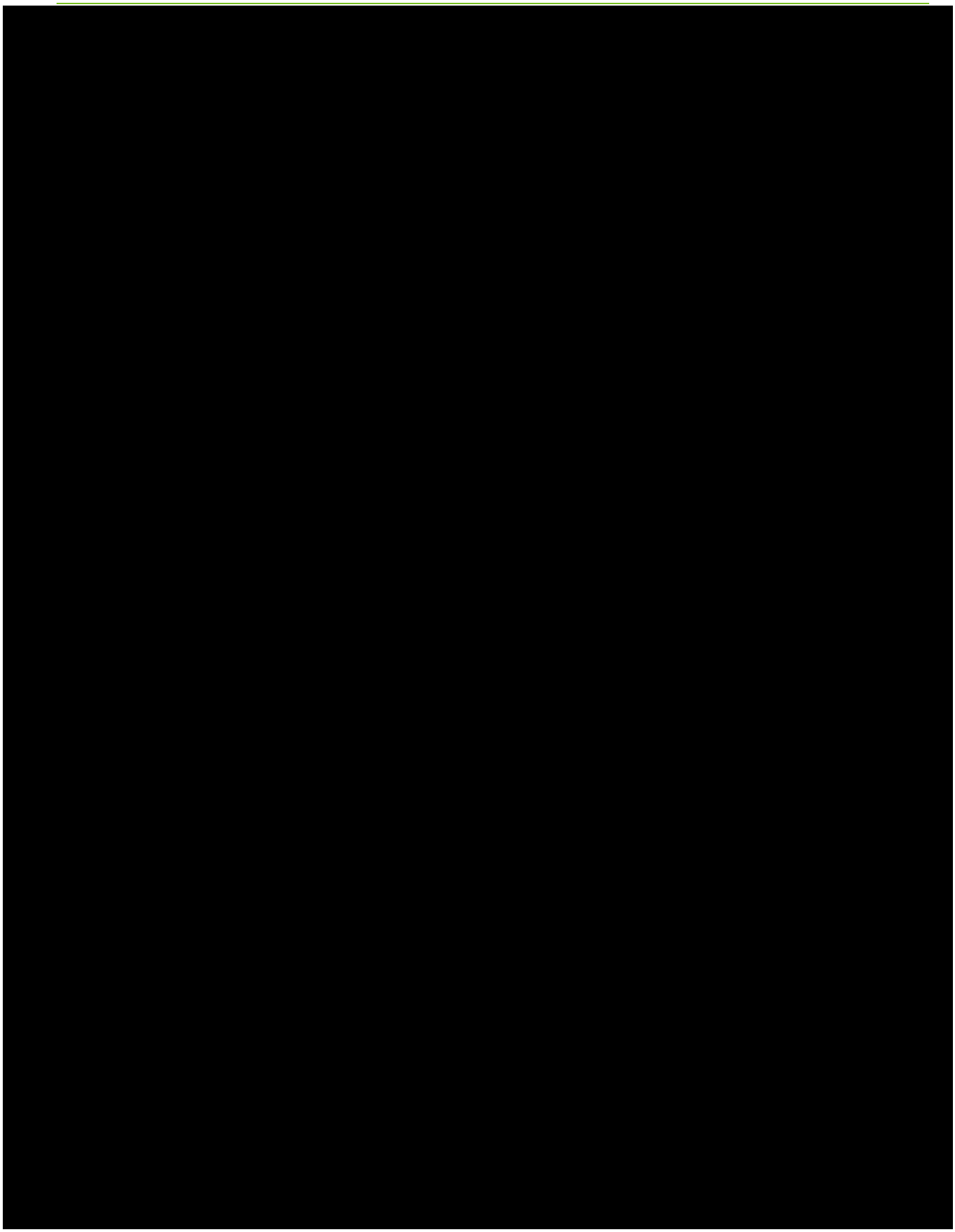


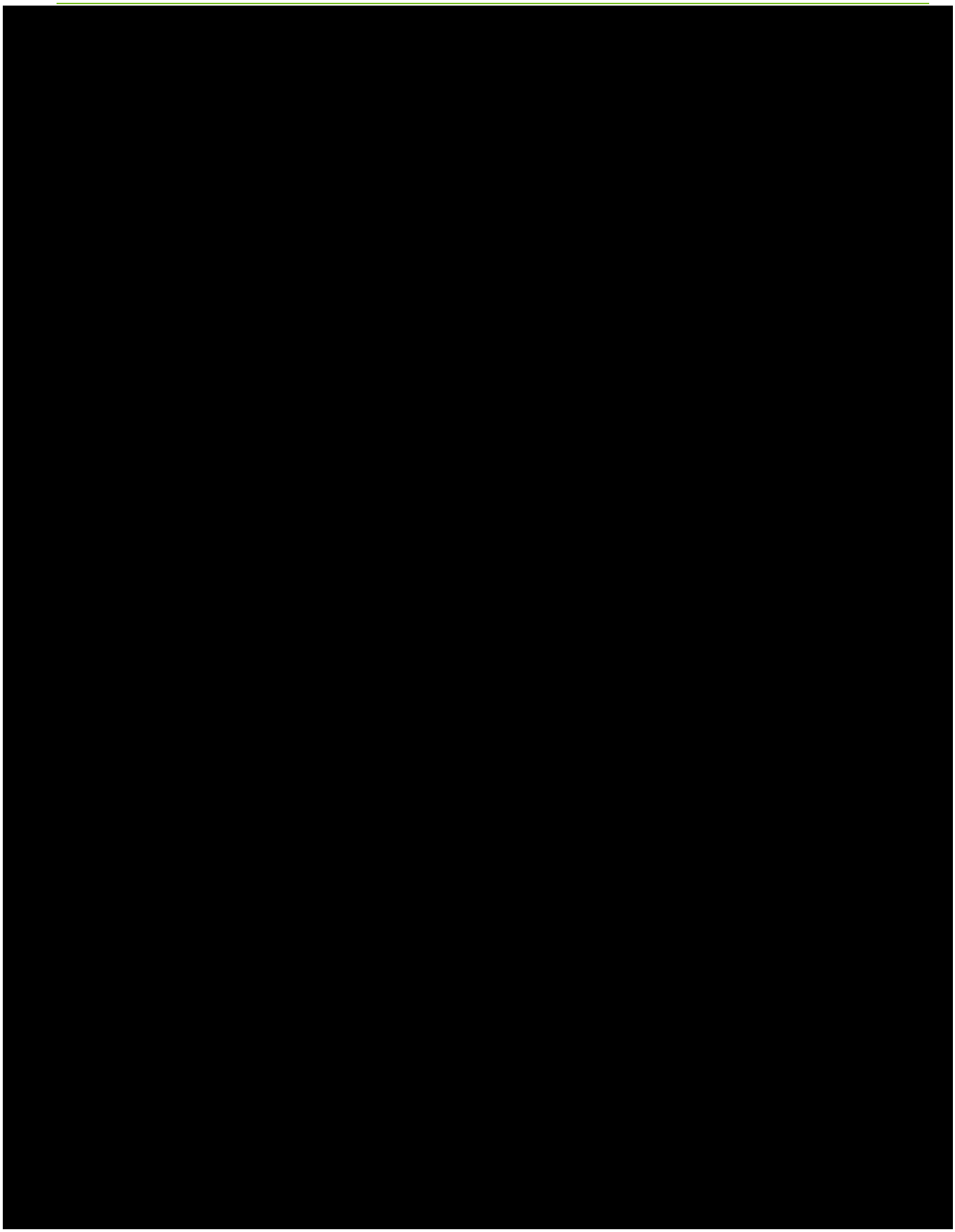


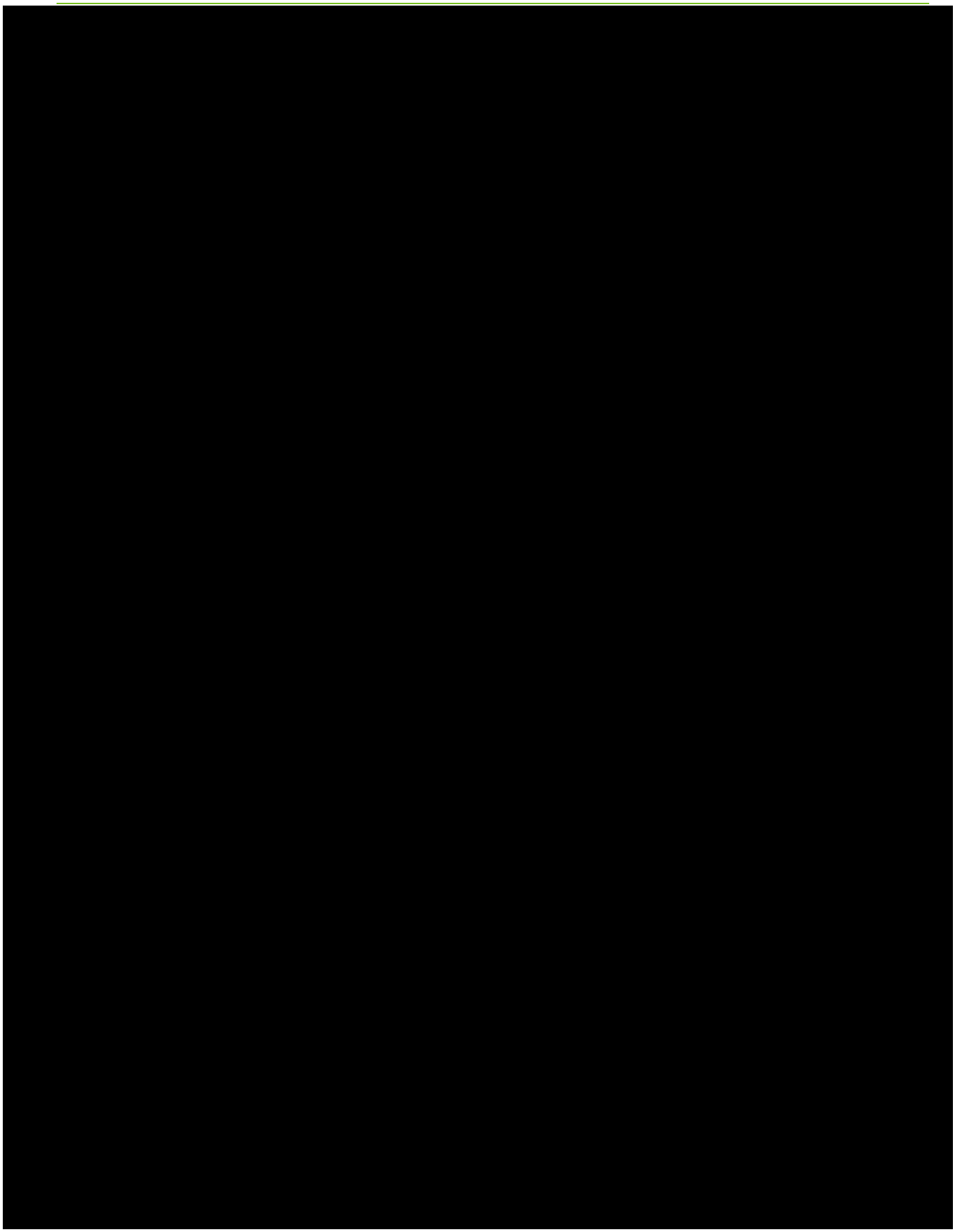


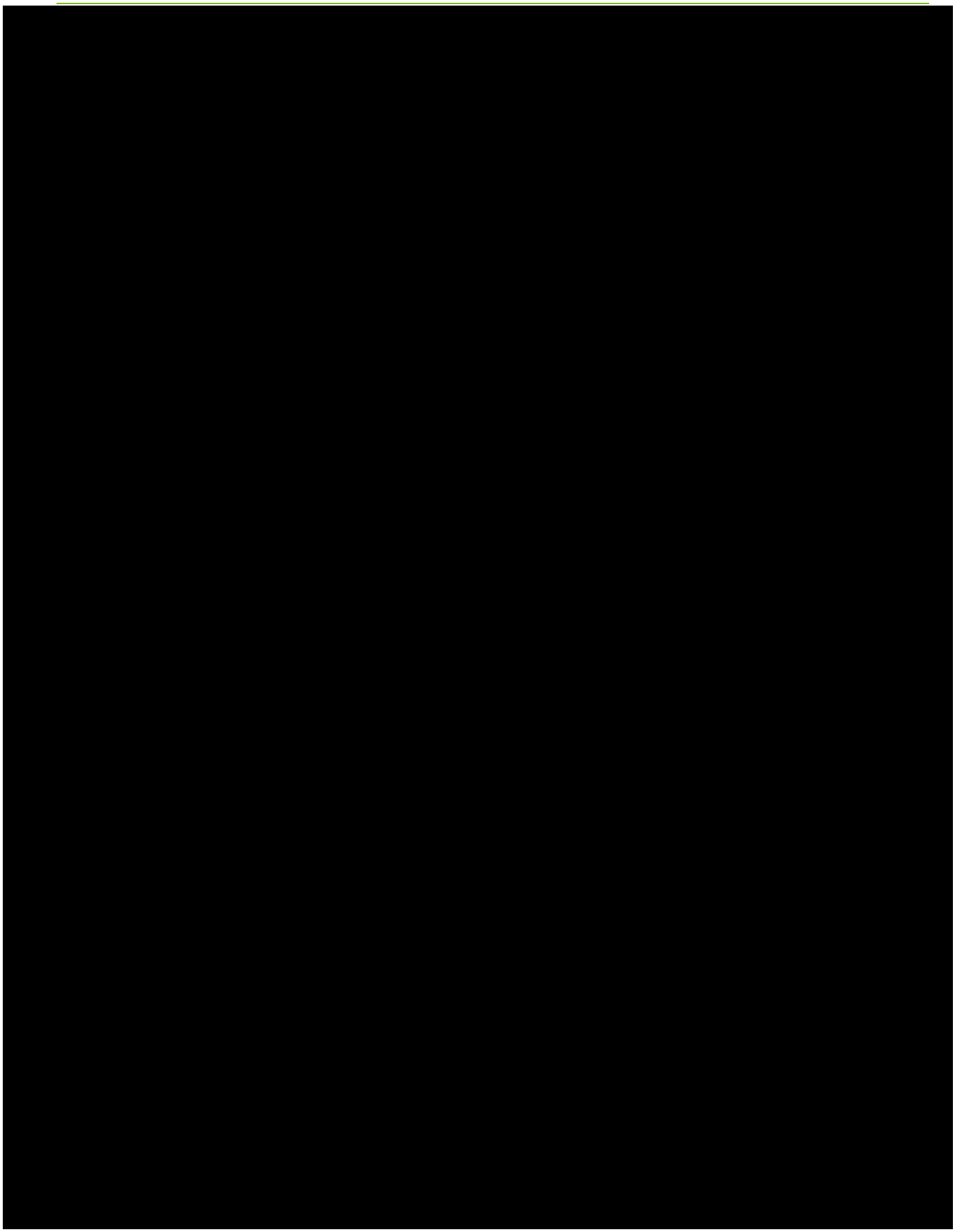


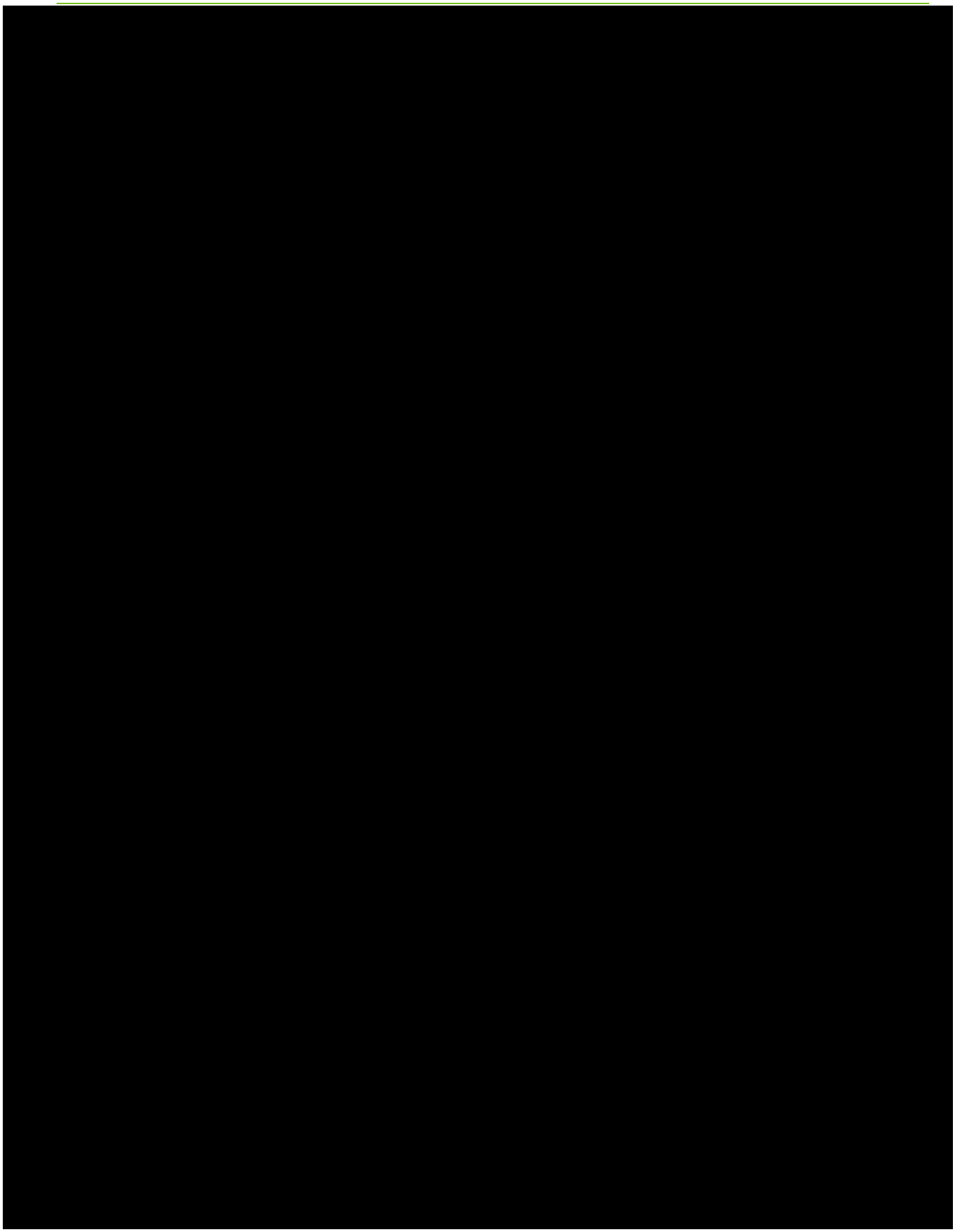


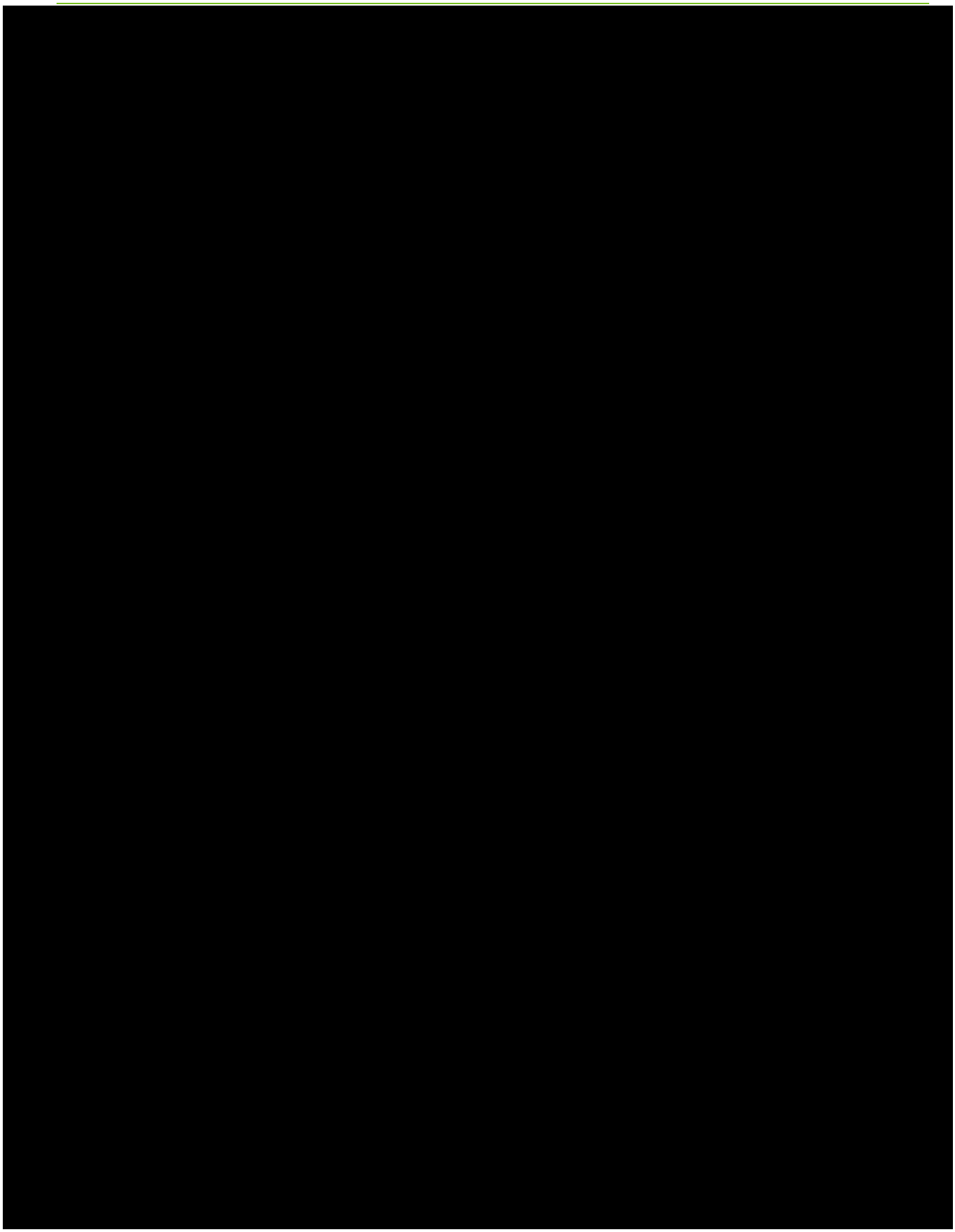


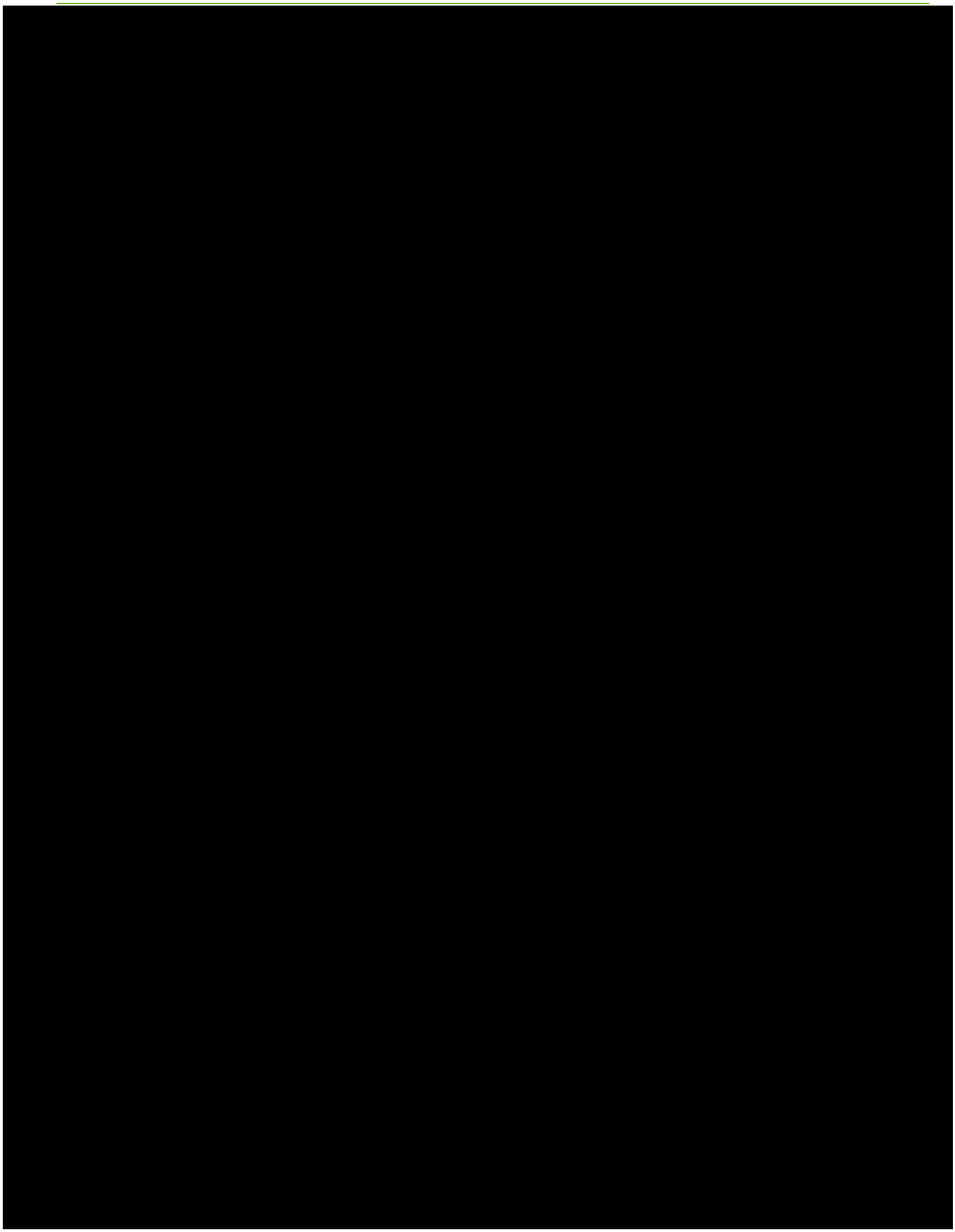


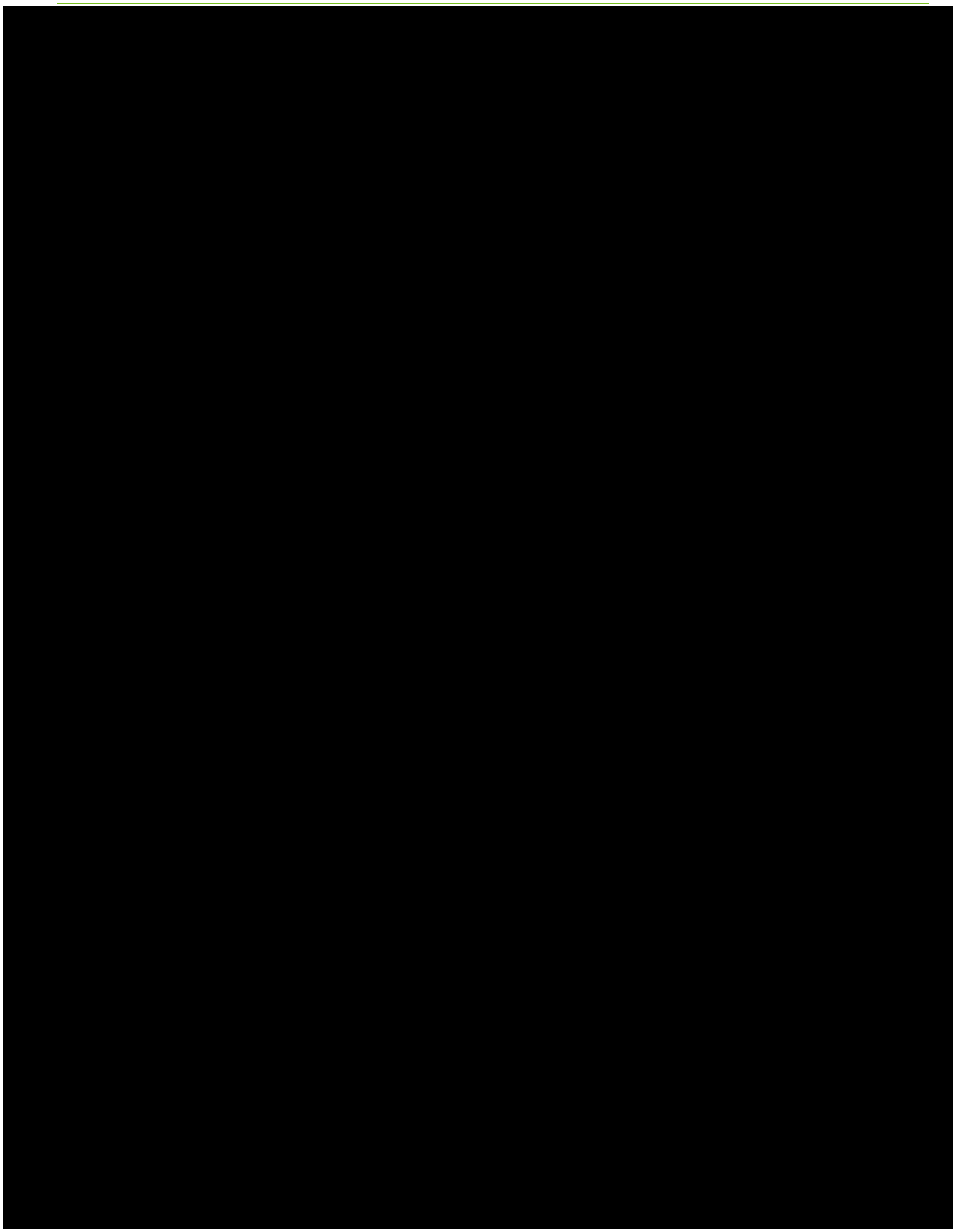


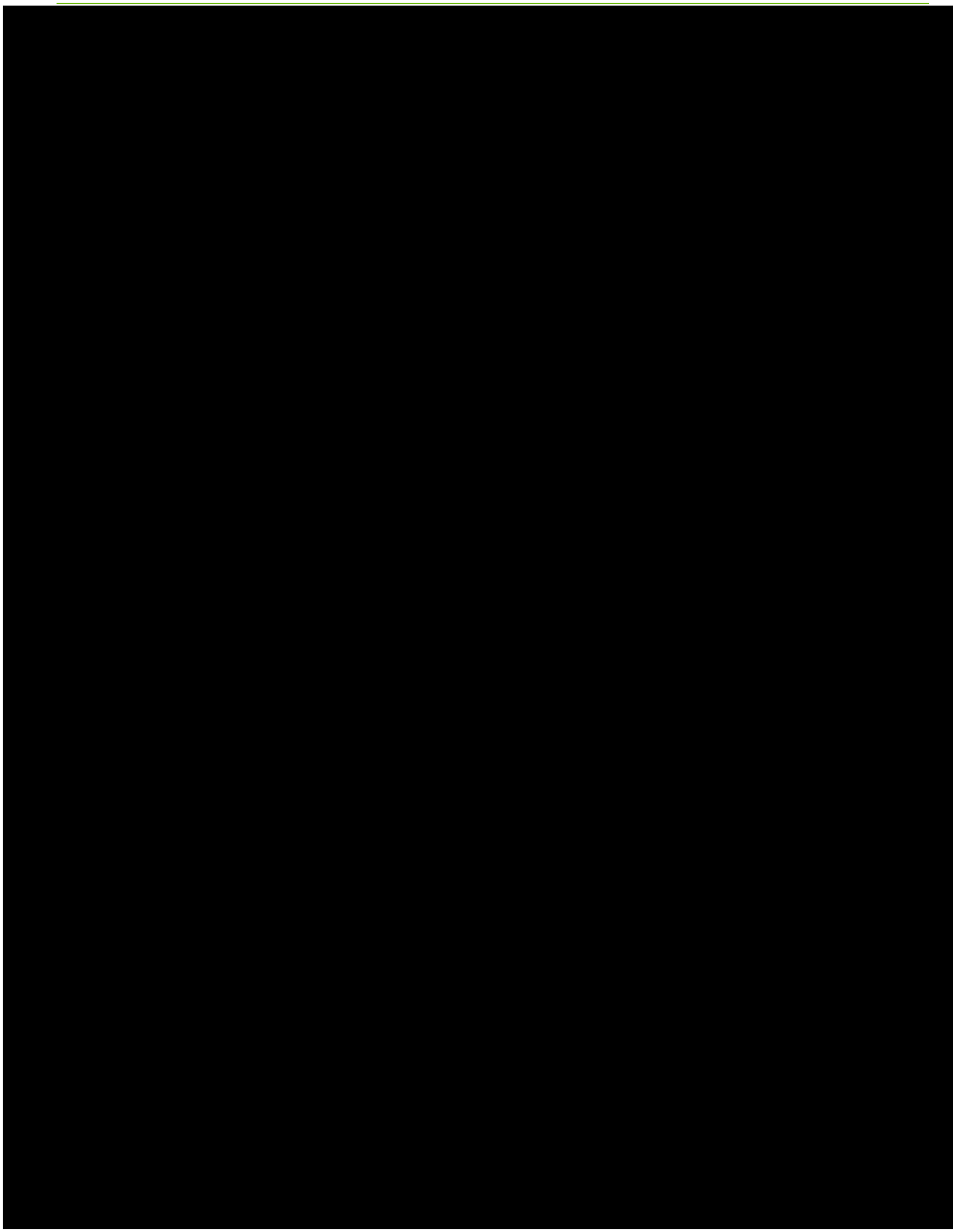


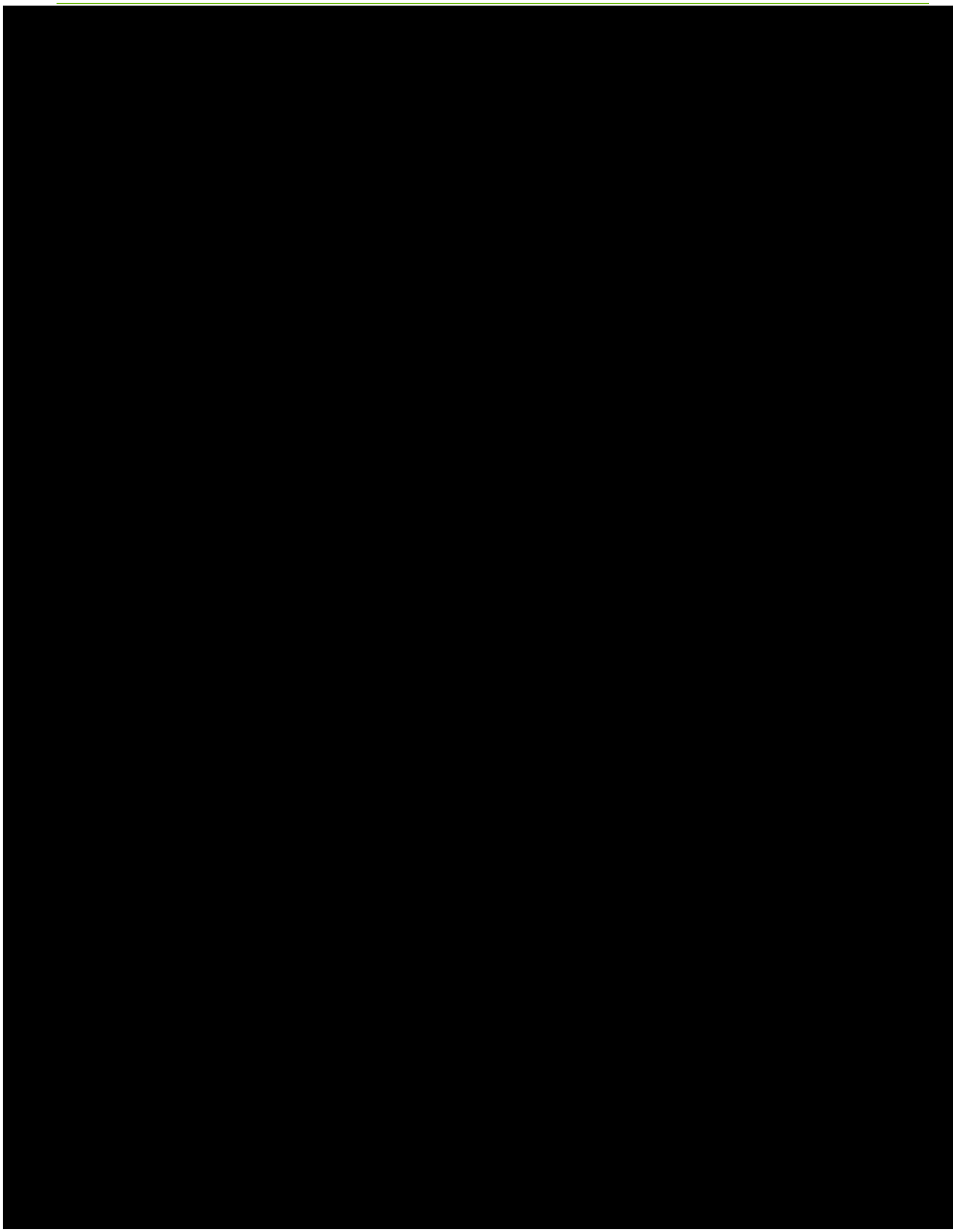


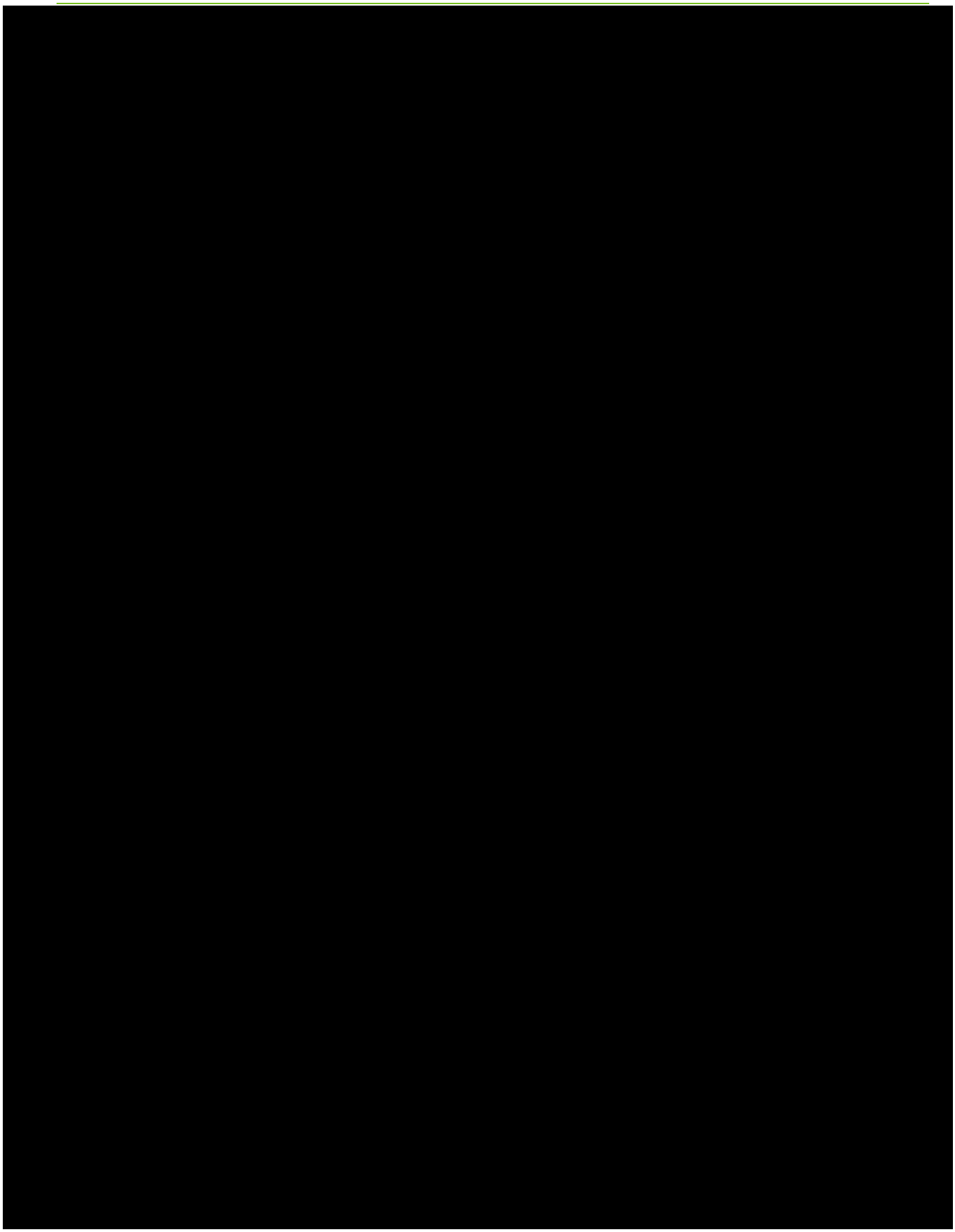


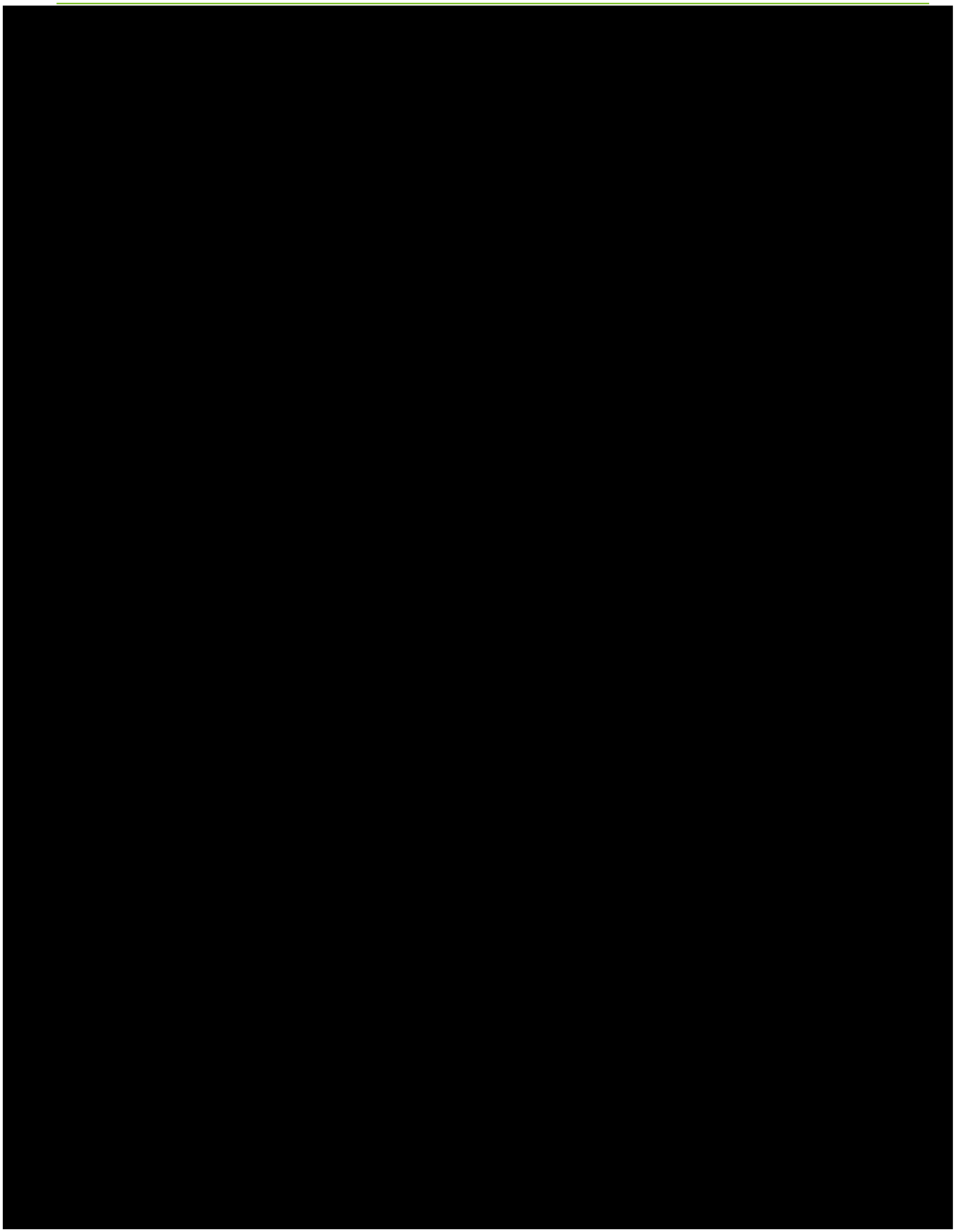


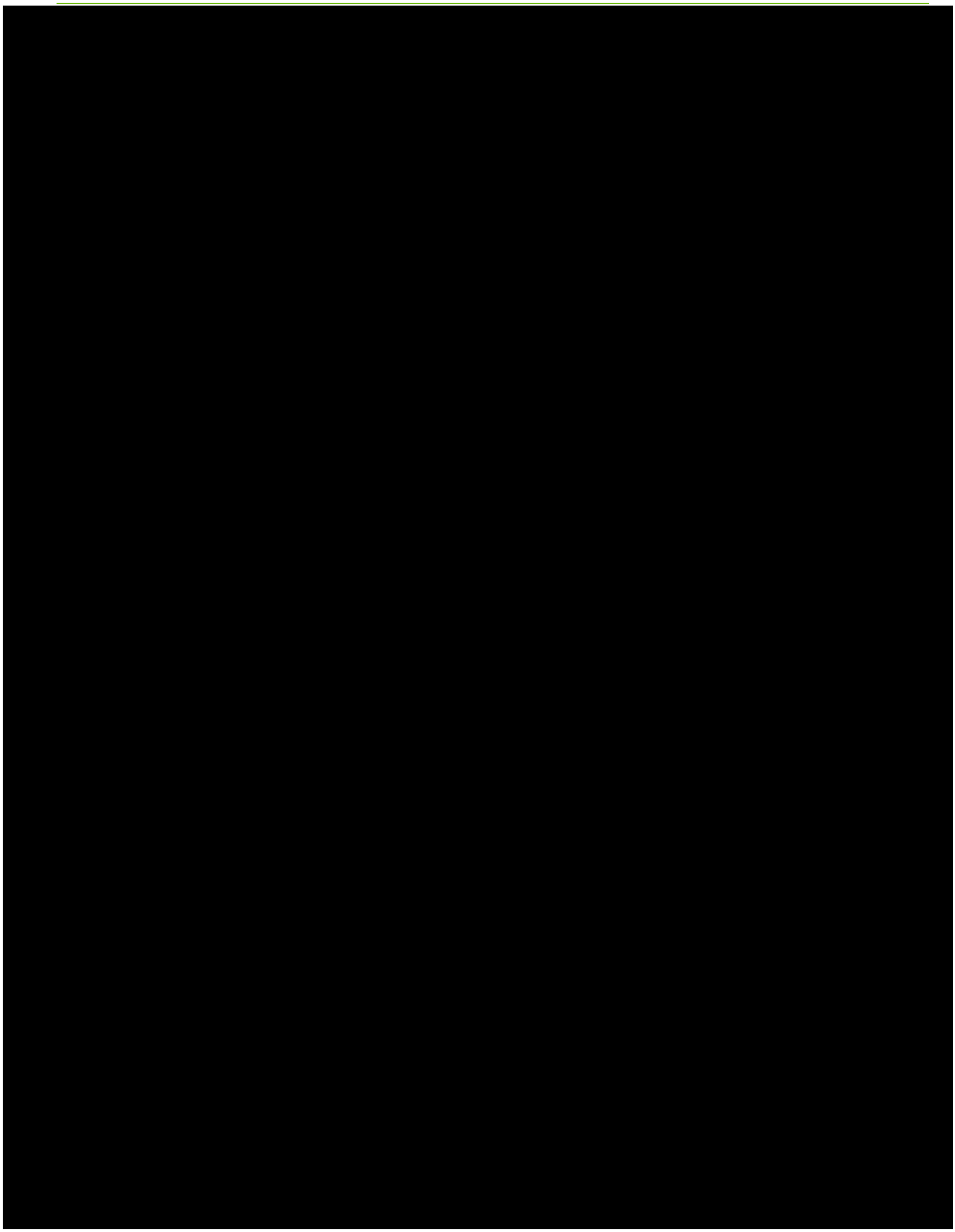


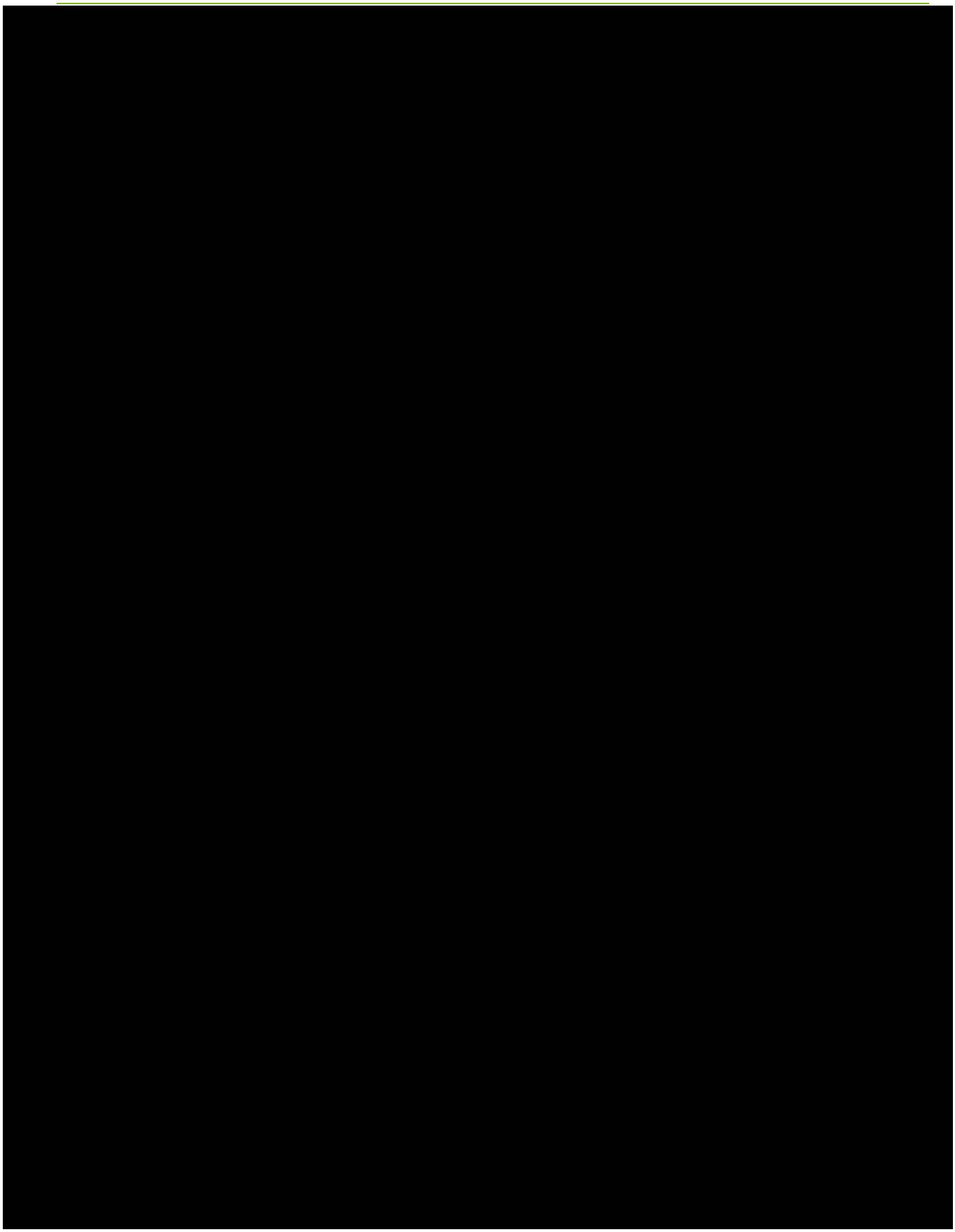












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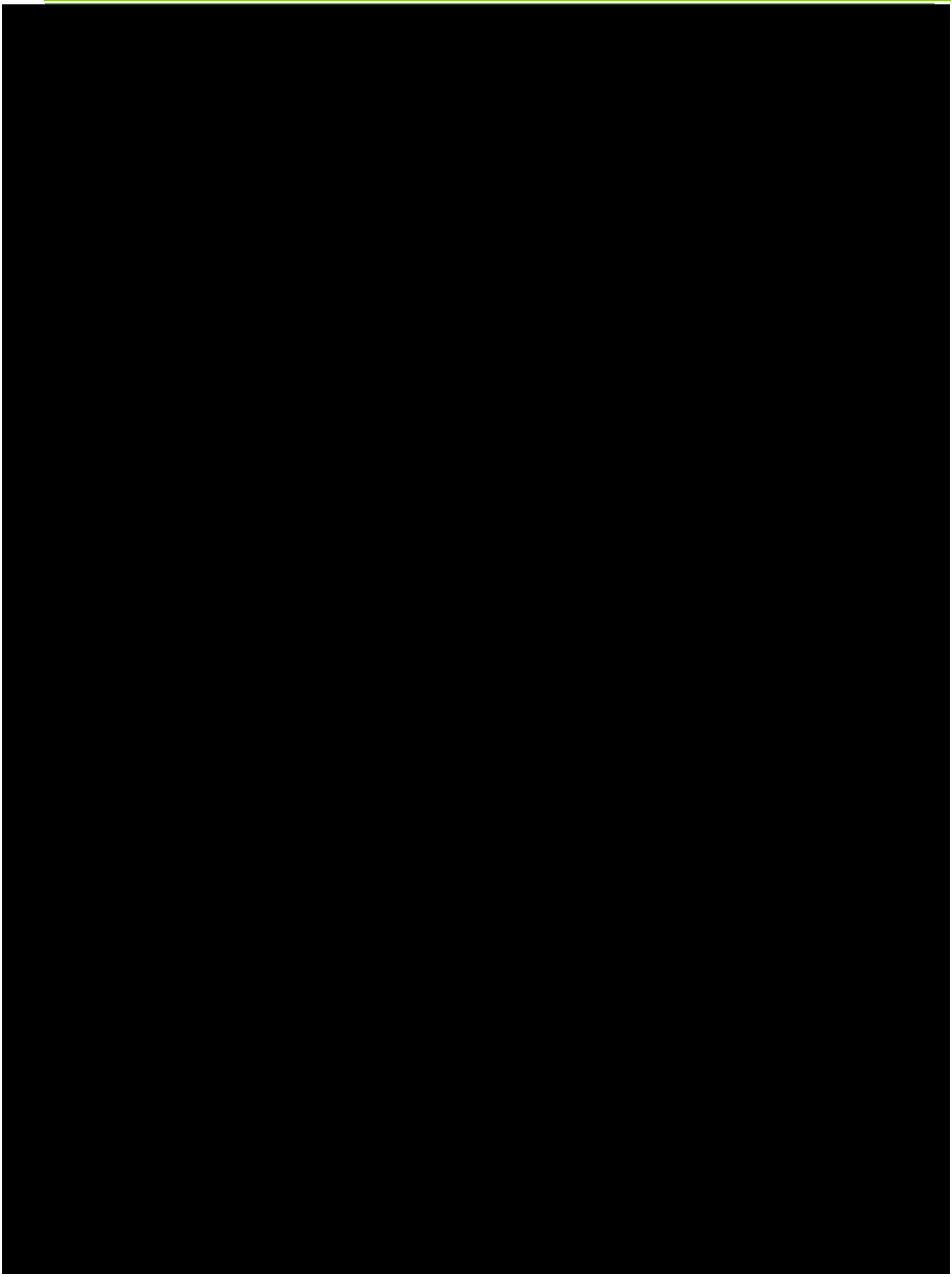
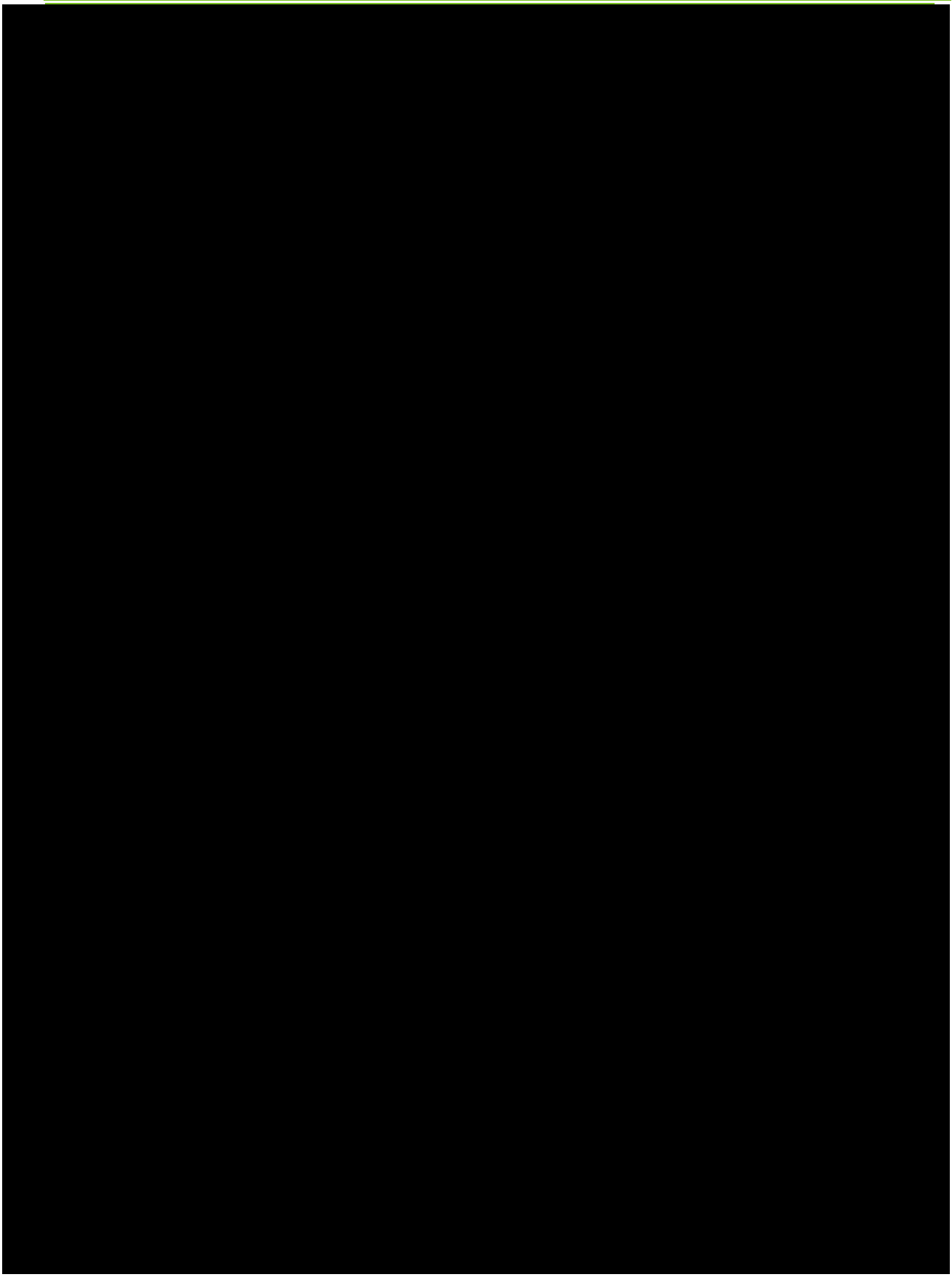
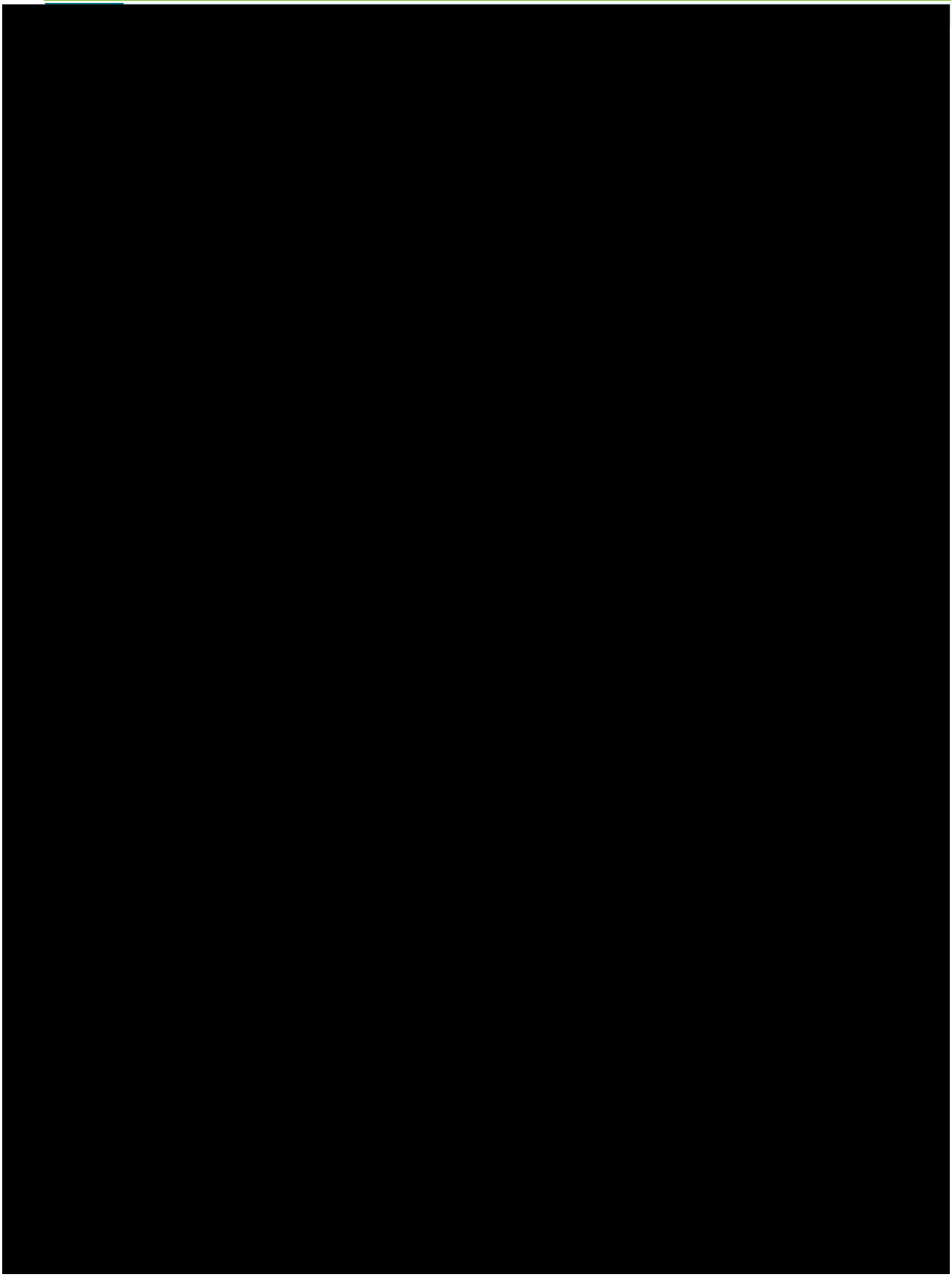
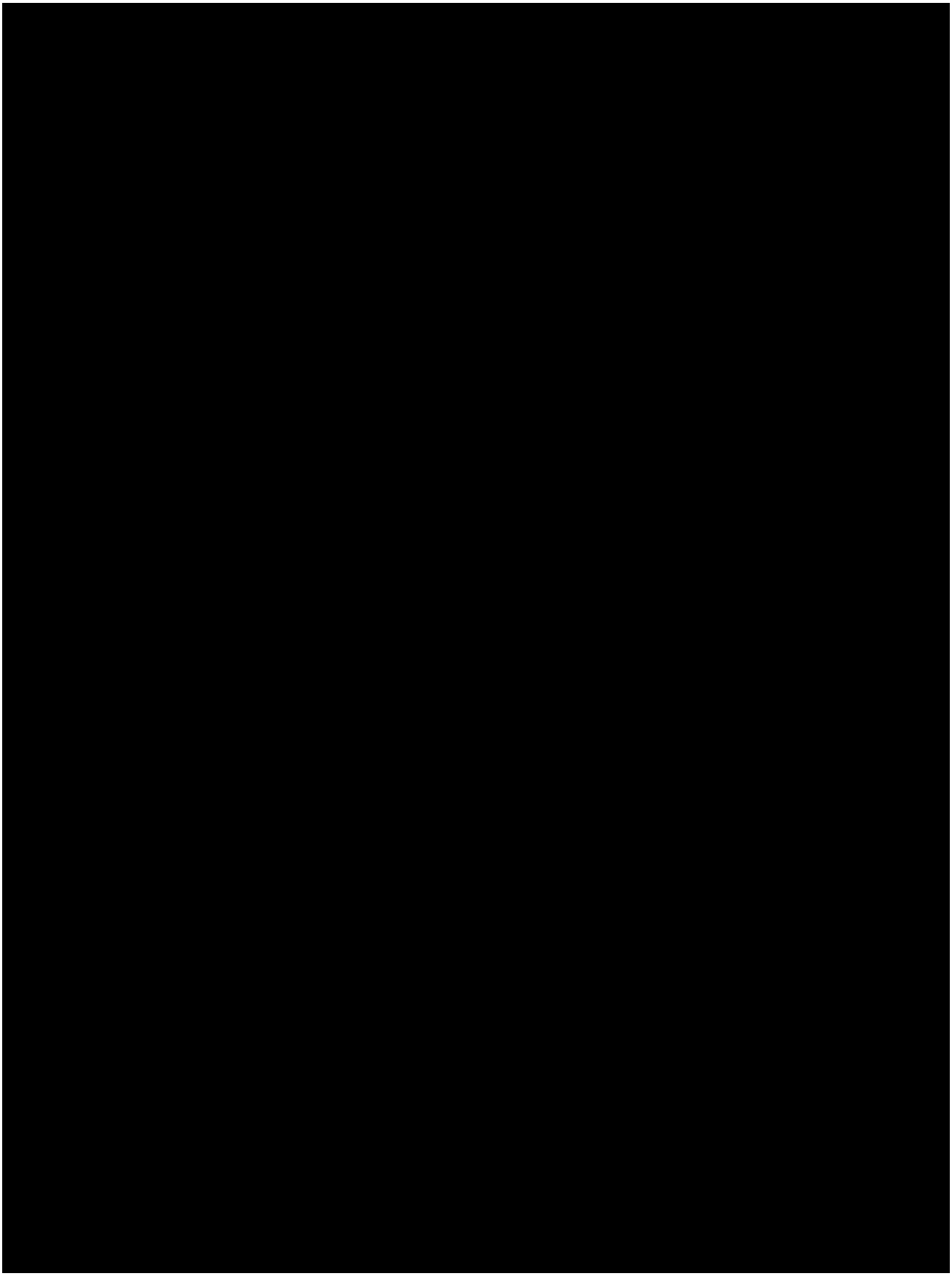
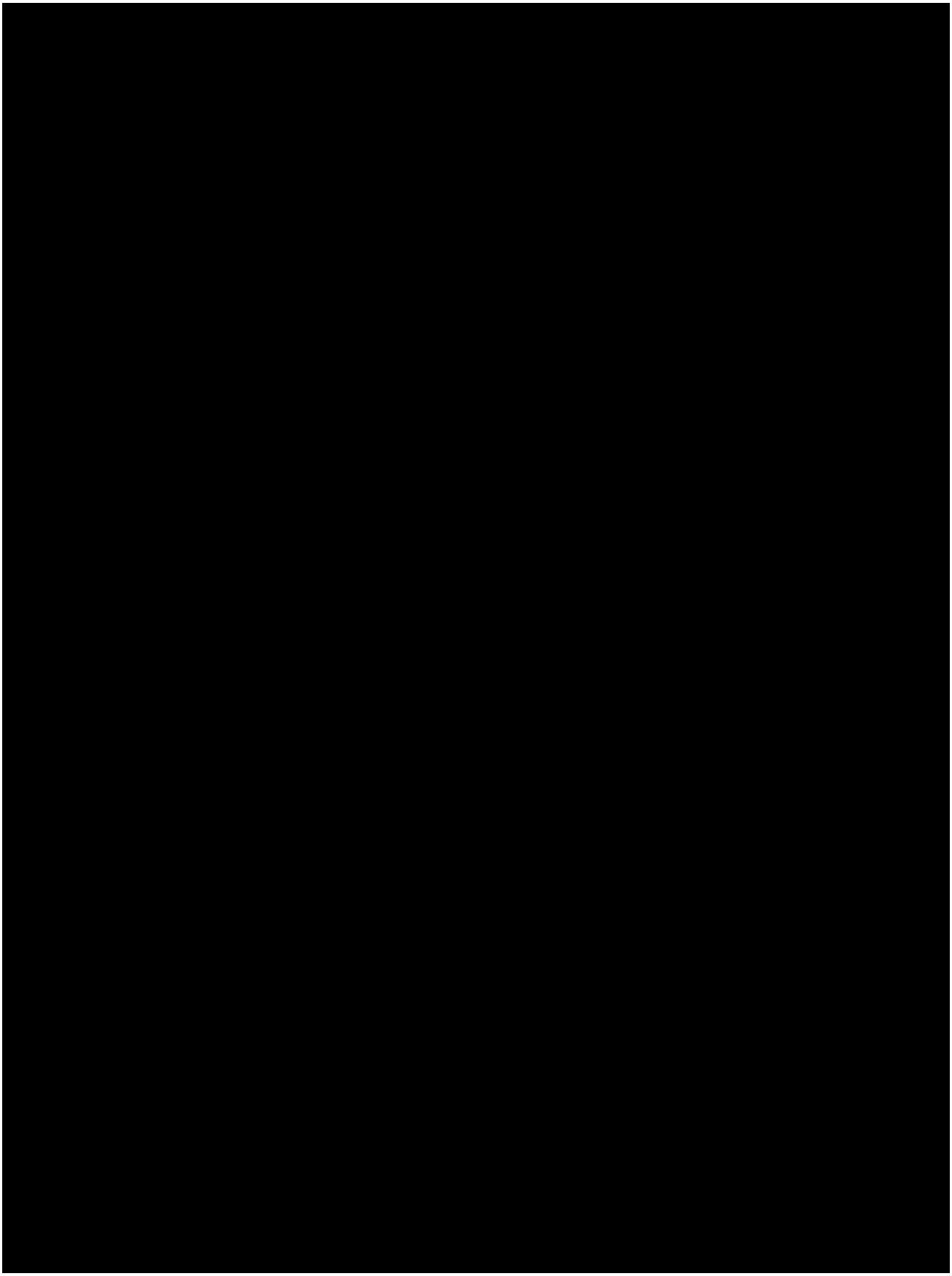
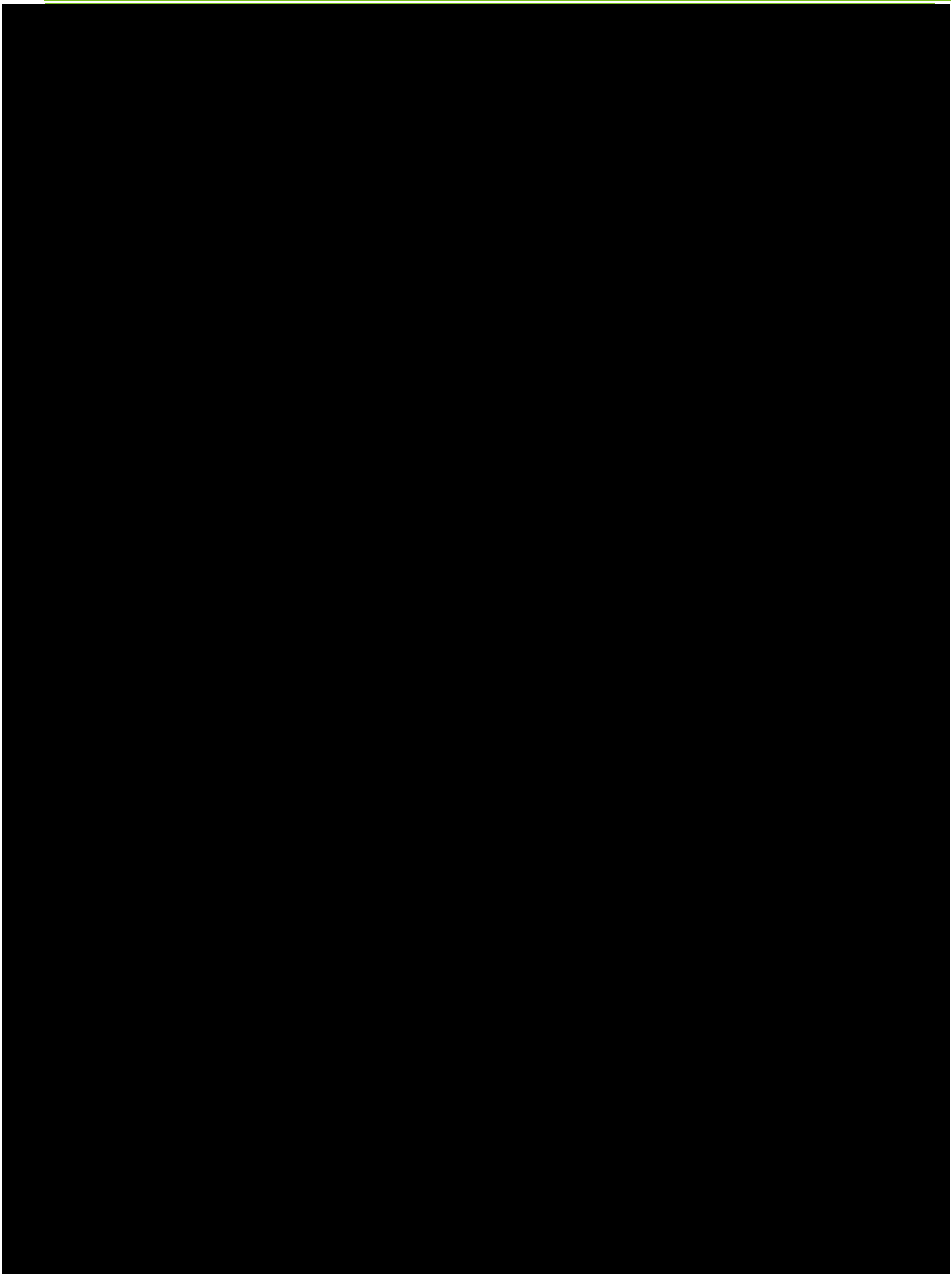


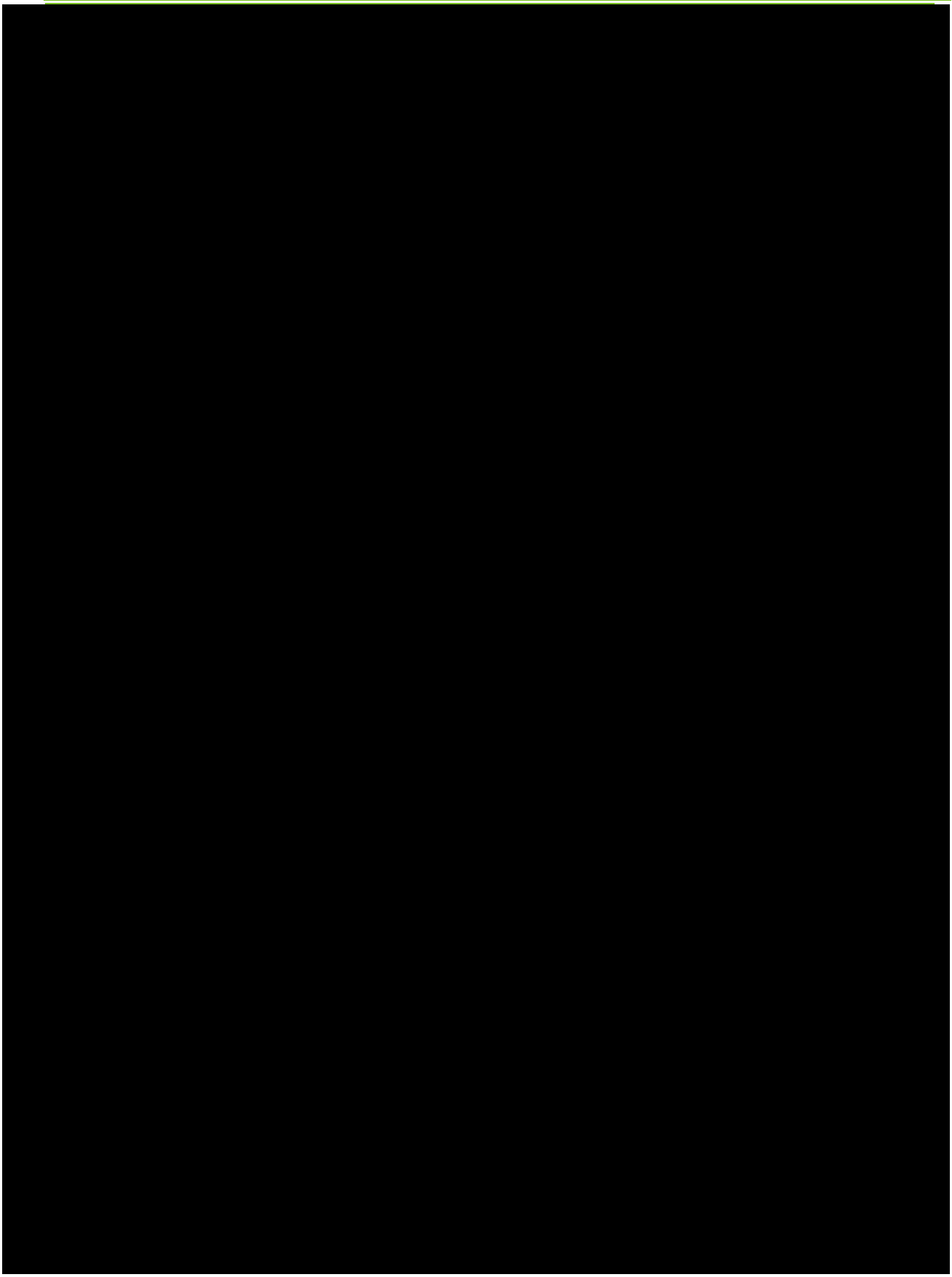












Healthy cooking demonstration at the Makin' Groceries Mobile Market kick-off event. Humana sponsors the Makin' Groceries Mobile Market, improving access to food and essential resources in rural communities across Acadiana.

Section 2.6.8

Network Management

Humana

Healthy Horizons™
in Louisiana

2.6.8 2.6.8 Network Management

Humana Healthy Horizons in Louisiana confirms adherence to **Model Contract Section 2.9 and Attachment F, Provider Network Standards**.

2.6.8.1 Ensuring Timely Access to Culturally Competent Primary and Specialty Care Services

Humana Heathy Horizons in Louisiana is building a qualified network by cultivating an agile, responsive, and diverse set of providers who deliver high-quality care to our enrollees in a culturally humble manner. We strive to achieve access for all enrollees, including those that live in the more than 80% rural areas of Louisiana and the more than 60% of Louisiana Medicaid enrollees who are Black, Hispanic/Latinx, Asian, or other minorities, including enrollees who identify as LGBTQI+, are of Vietnamese or Honduran descent, or living with disabilities. **By aligning with providers of diverse backgrounds in every parish using innovative contracting techniques, value-based payment (VBP) mechanisms, and enhanced provider partnerships, we build a network that reflects our enrollees and understands their needs**. Humana has been providing services in Louisiana for more than 35 years with staff who live and work in Louisiana and are active members of their communities. We have Medicare Advantage plans in every parish, paying out $1.81 billion in claims in 2019. We currently contract with more than 1,900 adult primary care providers (PCPs), 400 OB/GYNs, 2,000 behavioral health (BH) providers, 1,100 pharmacies, and 15,000 Medicare and commercial providers to serve our more than 450,000 Medicare, Duals, commercial and prescription drug plan (PDP) enrollees. **Humana currently has value-based arrangements with 37 physician groups, covering more than 120,000 enrollees.**

Ensuring Access to Culturally Competent Services: We conduct annual Health Equity Analysis, (access and adequacy assessment) of the cultural and linguistic needs of our enrollees and their geographic concentration. Our local, community-based Network Management team analyzes our provider network to ensure access to appropriate, culturally competent care. **For example, the top three non-English languages spoken by our Louisiana providers are Spanish, French, and Hindi.** To identify and address health disparities, we stratify our HEDIS® results by age, race, ethnicity, gender, and ZIP code to share insights with our network providers and inform their service delivery approach for their member panel.

In addition to contracting with providers accepting new Medicaid enrollees, we identify and target priority providers who traditionally serve Medicaid enrollees. As of early August, our Medicaid network includes more than 95% of Louisiana's federally qualified health centers (FQHCs), 85% of rural health clinics (RHCs), and over 92% of the Critical Access Hospitals. Additionally, we have entered into contracts with several of the children's hospitals in the State, including Our Lady of the Lake Children's Hospital and Louisiana Children's Medical Center in New Orleans as well as all of the publicly funded (i.e., public-private partnership) hospitals. **We have an extensive behavioral network that includes 9 of 10 Human Service Districts (HSDs), 30 of 37 Substance Abuse Residential Treatment Facilities, and 16 of the 17 Assertive Community Treatment (ACT) providers.** We continue to meet with providers across the State and are confident the remaining providers will participate **once we are awarded a contract.** In keeping with our commitment to meeting enrollees' needs with a **culturally humble, fully integrated network,** we offer social determinants of health (SDOH) closed-loop referrals through a network of community-based organizations (CBOs), including food banks, housing agencies, workforce development specialists, and domestic violence advocates and shelters.

2.6.8.2.1 Work Plan for Building Provider Network to Meet Adequacy Standards

Humana began building our Medicaid network more than two years ago—in advance of the release of the 2019 RFP—encouraging our commercial, Medicare, and TRICARE providers to join our Medicaid network. We used our extensive experience in Louisiana to inform our plan, building upon our knowledge of the State, its demographics, and challenges, including the significant statewide provider shortages. We are leveraging this experience and our strong provider relationships to develop our

Medicaid network and encourage providers who traditionally have not accepted Medicaid enrollees. For example, [redacted] Additionally, we have committed to build three primary care clinics prioritizing Medicaid-eligible adults in partnership with Ochsner Health focusing on areas with primary care access challenges. In accordance with **Model Contract Section. 2.9.27,** we will supply a copy of the complete work plan during Readiness Review**.** Please see **Table 2.6.8.2-1** for our Timeline to Build Network to Meet Network Adequacy Standards. A summary of our Network Development Work Plan to **develop, maintain, and monitor an appropriate provider network, and address network gaps** follows.

Table 2.6.8.2-1 Timeline to Build Network to Meet Network Adequacy Standards

Milestone	Start Date	End Date
Create Network Development Work Plan and Strategy	March 2019	March 2019
- Define Provider Contracting Requirements	March 2019	March 2019
- Ongoing Monthly Adequacy Assessments*	March 2019	December 12, 2021*
Recruiting and Contracting/Credentialing*	April 2019	December 12, 2021*
Identify and Resolve Network Gaps	April 2019	December 12, 2021*
Reassess and Update Network Development Work Plan, Strategy, Provider Contracting Requirements**	July 24, 2021	July 27, 2021
Readiness Review	December 13, 2021^	April 1, 2022^^
*ongoing throughout term of our contract with LDH **based on new RFP requirements	^on or about, per RFP Section 1.6 ^^estimation per Model Contract Section 3.1.5.1	

Assessing Work Plan Needs and Strategies in Accordance with Contract Requirements: Our Network Development team performed a regional assessment of the demographics and clinical needs in urban and rural areas through face-to-face meetings with providers in each region, geo-access analysis based upon time and distance standards, and analysis of the competitive landscape. Following this analysis, this locally based team developed our Work Plan to grow our Medicaid network. **In accordance with Model Contract Section 2.9.27, this Plan includes topics such as geographic analysis by provider type, region, parish, enrollee characteristics/demographics, and access and adequacy standards.** It also summarizes our strategy for recruiting providers, which we describe in **Section 2.6.8.2.3**.

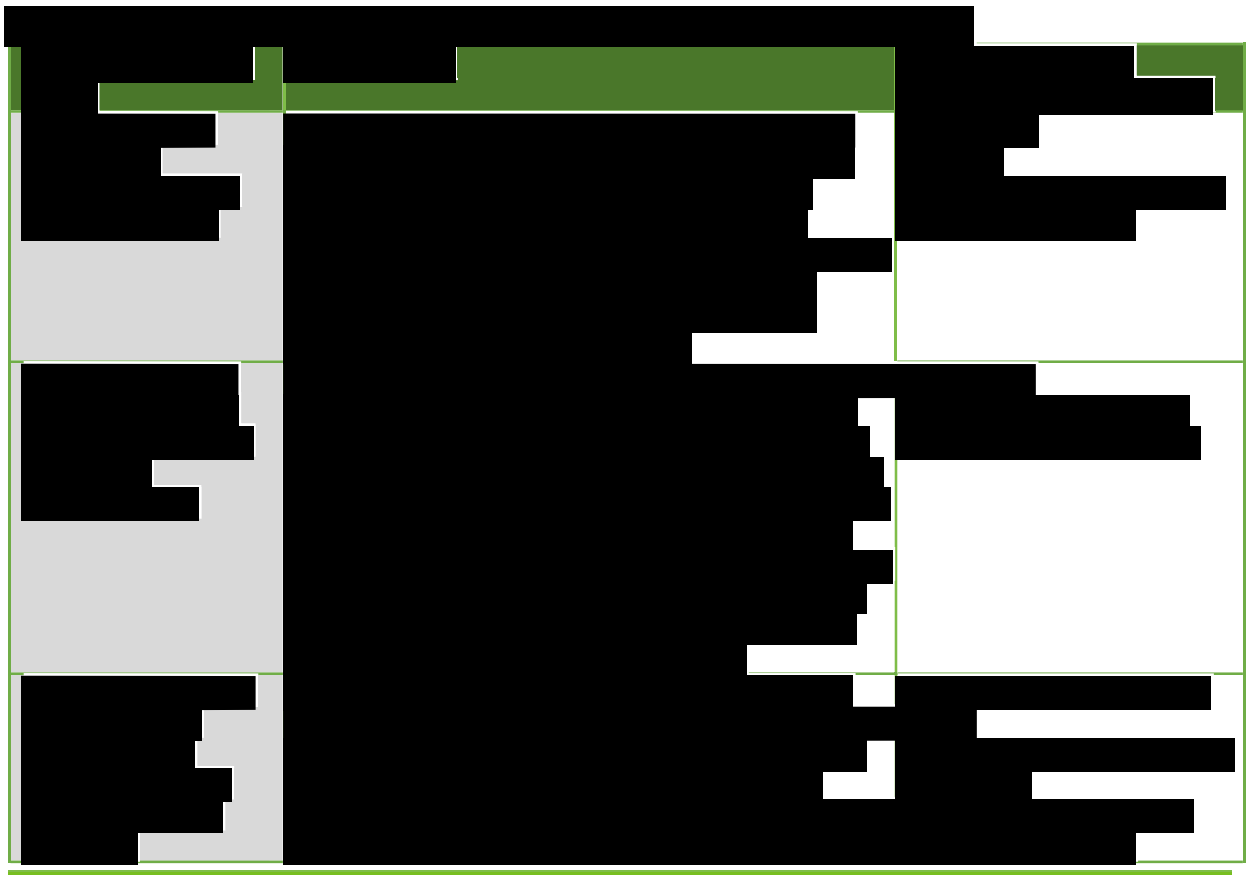
We have expanded our relationship with Ochsner Medical Center to develop three primary care clinics anticipated to be in underserved areas such as Shreveport, Monroe, and the greater New Orleans areas to prioritize access for Medicaid-eligible adults in areas with access challenges.

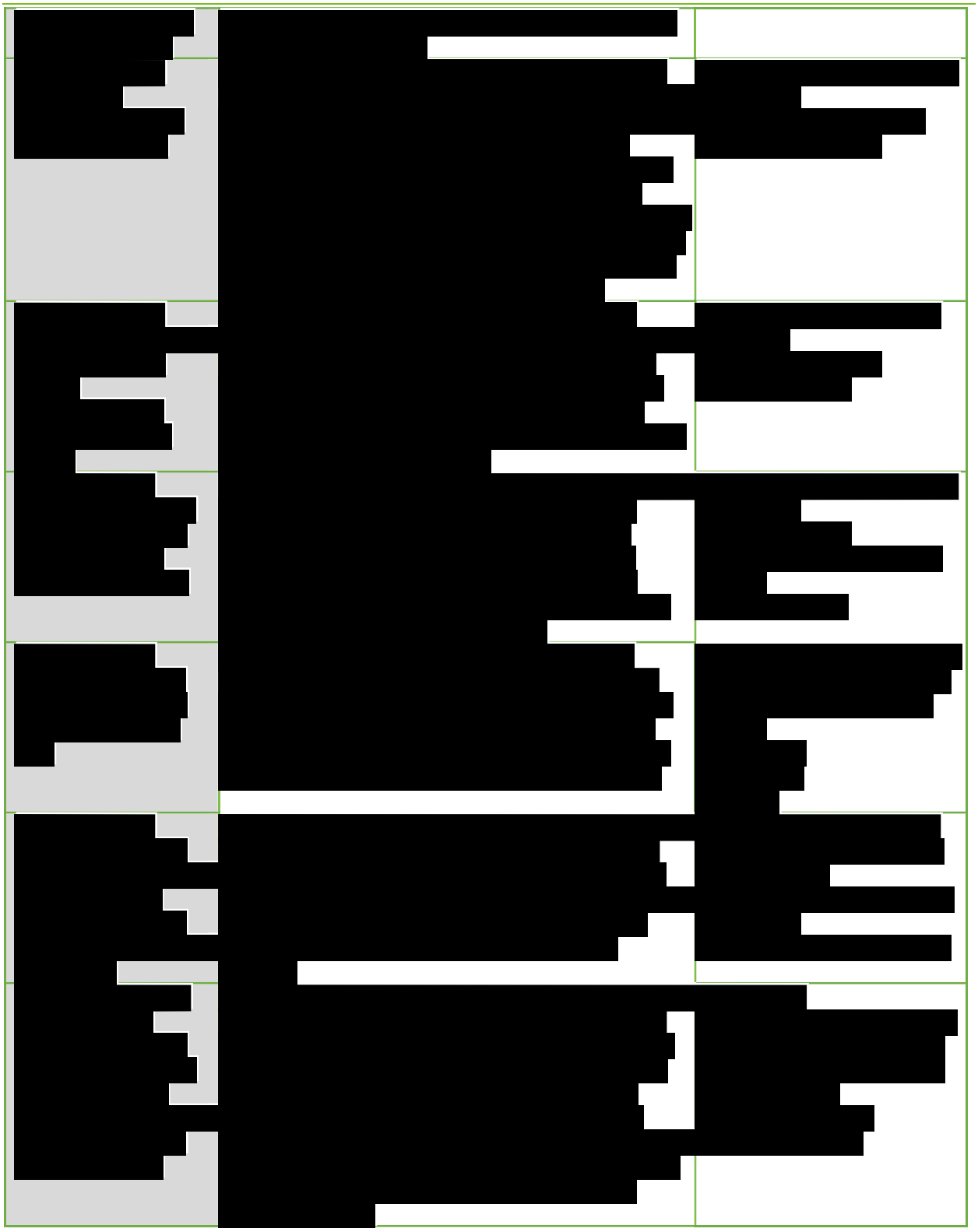
Recruiting, Contracting, and Credentialing Providers: Our [redacted] Through this multifaceted approach, we have secured Medicaid relationships with nearly **2,000 PCPs**, **more than 1,100 pediatric PCPs**, and **more than 430 OB/GYNs**. Our extensive BH network includes **2,200 BH specialists** in Child and Adolescent Services, Functional Family Therapy, Multi-systemic Therapy, Homebuilders, and **Applied Behavioral Analysis in all nine regions** and contracts with substance use **residential treatment facilities in eight of nine** regions.

Following recruitment, our Network Contracting team facilitates execution of a network agreement, and our Credentialing team credentials providers following the requirements in **Model Contract Section 2.9.30**. Upon completion of the readiness review, we will conduct provider **orientation** in all nine Louisiana regions and ongoing **training and education**, including virtual town halls as needed.

Identifying and Resolving Gaps: To identify gaps, our Network Management team queries Quest Analytics, a state-of-the-art network analytics/geo-access tool, by region and specialty. Based upon the output from that gap analysis, the team uses the CAQH and our proprietary internal data platforms, including lists of licensed providers in each region/parish, to determine the potential recruitment targets in each region/specialty. Next, we review our contracting history with the provider; **if the provider is under an existing contract that does not include Medicaid, we reach out to amend the contract to encompass Medicaid**. If the provider is not currently contracted in any of Humana's other lines of business, our Network Development team evaluates whether the provider would be a good fit for Medicaid enrollees. The team documents the outcome of our efforts in Quest Analytics to track provider contacts. We continue with this process until we address the gap. Regardless of this strategy, Louisiana has provider shortages across all nine regions that require innovative strategies to ensure access. Strategies we use across all regions include **single case agreements, letters of agreement, mobile health, telehealth, and accessing our national contracts for services** such as hemodialysis, specialty BH, and labs. We will also access providers in other states such as Texas, Arkansas, Mississippi, and Oklahoma to fill gaps in border regions (See **Section 2.6.8.2.3** for specific strategies to address gaps and **Section 2.6.8.2.4** for descriptions of these innovative approaches). See **Table 2.6.8.2-2** for an analysis of our most significant, current gaps and strategies to increase access.

Our Rural Concierge Unit will use a continuous improvement methodology to examine our rural health network to evaluate access challenges and identify solutions to the challenges.





2.6.8.2.2 Identifying Network Gaps

Humana continuously evaluates timely enrollee access to providers with a comprehensive set of monitoring tools to identify any gaps. Our network adequacy process measures network performance

against contractual requirements, allowing us to identify and resolve network gaps, address barriers to care, and enhance preventive care. Using software from Quest Analytics, we can view a full picture of our network's adequacy and accuracy, identifying actionable data and insights to help prioritize our activities. We assess capacity in each region across all available provider types monthly for compliance with network adequacy standards and after-hours availability, which is reviewed by multiple committees, including our Quality Improvement Committee, to identify solutions. Tools we have used since March of 2019 to identify gaps in our Louisiana Medicaid network appear in **Table 2.6.8.2-3**.

Table 2.6.8.2-3: Examples of Tools to Identify Network Gaps

Purpose	Description of Tools	Frequency
Distance Standards Measurement Tools	**Time and Distance Standards**: Humana uses geo-access to map membership to provider locations, measuring both distance and travel times. We analyze access for each provider specialty by enrollee as indicated by provider type.	Monthly
	Enrollee-to-Provider Ratios: We determine provider capacity assessment by incorporating standards defined by LDH, internal experience, and national standards. When we identify that any tracked provider has reached at least 85% of their established capacity, we proactively begin recruiting new providers of that provider type in the identified geographic area.	Quarterly
Appointment Availability and After-Hours Care Measurement Tools	**After-Hours Accessibility Audit**: Humana calls provider offices to ensure enrollees have enhanced access to care after-hours.	Quarterly (minimum)
	Secret Shopper Calls: We will use secret shopper telephone surveys for providers who served 10 or more enrollees during the prior six months.	Ongoing
	Patient Experience Interactive Voice Response Call: Using our affiliate Florida Medicaid plan's experience, we will survey enrollees to solicit feedback on their experience with providers. We will aggregate the data by practice group or region and use to inform Joint Operating Committee meetings.	Ongoing
Open/Closed Panels Measurement Tools	**Review of Open and Closed Panels**: We review the panel status of our PCPs by parish and region to identify access barriers and implement additional targeted recruitment efforts. Upon identification of a closed panel, we review network PCPs in the same geographic area to ensure there are enough PCPs with open panels to provide access.	Quarterly
	Clinic Availability: We conduct real-time analysis of provider complaints to identify red flags, with market-based operational and quality forums assisting with root cause analysis.	Ongoing
Health Equity Assessment	**Language and Culture:** We analyze the linguistic and cultural needs of enrollees to determine gaps in our network.	Ongoing

2.6.8.2.3 Strategies to Increase Provider Capacity and Meet Enrollees Needs When Network Gaps Exist

While our network monitoring approach focuses on proactively identifying access issues, we have response mechanisms to rapidly facilitate provider access when necessary. Below are examples of our strategies to increase provider capacity:

Investment in Louisiana's Provider Landscape: We are funding the development of **three primary care clinics** with Ochsner to expand access to underserved Louisiana communities that we have identified through our community needs assessment: Shreveport and the surrounding Caddo Parish, Monroe and Ouachita Parishes, and New Orleans and Orleans Parishes. [redacted]

[redacted]

Through our partnership with Quantified Ventures, we are collaborating with the City of New Orleans to establish a series of workforce development interventions aimed at addressing SDOH issues and reducing gun violence, including CEO Works, Opportunity Youth Jobs Program, a Regular Summer Jobs Program, and Pathways Program.

Development of innovative strategies requires a deep understanding of each community and its unique needs to customize solutions; there is no "one size fits all" strategy. For example, in Louisiana, the percentage of adults with diabetes is highest in rural northeastern and northwestern parishes where access to care is challenging. **To address this, we have contracted with RestorixHealth At-Home Model program to visit enrollees in their homes to enhance access**. We have also developed several approaches to supplement our recruitment efforts (described in **Section 2.6.8.2.6**) and gap closure strategy (described in **Section 2.6.8.2.1**) to address network challenges. When we identify a gap, Humana launches a multipronged approach to meet enrollees' needs, reflected in **Table 2.6.8.2-4**:

Table 2.6.8.2-4: Strategies to Meet Enrollees' Needs

Short Term Strategy	Description
Single Case Agreements	Execute a single case agreement with out-of-network (OON) Medicaid providers (e.g., Shriners in Texas for burn treatment or Ochsner Hancock on MS Boarder).
Letter Agreement	Execute a letter of agreement with an OON Medicaid provider to deliver Covered Services or to allow any enrollee in a geographic area to access the provider.
National Providers	Coordinate with our Utilization Management (UM) department to identify national providers to provide the service (e.g., specialty BH providers for eating disorders, fire starters, etc.).
Telehealth	Offer and provide assistance in arranging telehealth services for Medicaid enrollees, including direct-to-consumer options (e.g., urgent and BH care, diabetes management, lactation support, postnatal care) and provider support to address rural areas, particularly in Calcasieu and Cameron Parishes that have suffered devastating losses due to recent natural disasters, and urban access challenges in Baton Rouge, Shreveport and Lafayette. [redacted]
Remote Monitoring and Support	Develop a remote patient monitoring pilot with the goal of reducing emergency department (ED) visits and hospitalizations for enrollees with chronic conditions, such as diabetes and COPD, and those who require post-acute care, such as daily monitoring of biometric readings to facilitate earlier intervention and encourage adherence to treatment plans.
Paramedicine	Partner with local emergency medical services entities and vendors to provide episodic care (e.g., for urgent needs or post-discharge care) and community-based care for frequent ED utilizers. These entities use technology to connect a network of neighborhood-based responders – emergency medical technicians, nurses, and firefighters supported via video with

	the best telehealth doctors – to patients who need nonemergent care wherever they are.
Border State Partnerships	Engage border state providers to play a significant role in filling gaps in access with providers such as Delta Medical in Mississippi and Memorial Herman in Orange, Texas.
Mobile Healthcare	Offer services through mobile health unit we fund or through one of our partnerships such as RestorixHealth, which provides in-home wound care, or our FQHC partners, particularly for enrollees with diabetes, across the entire state.
Physician Extenders and Peer Support	Provide scholarships to cover the cost of training or certification to expand access to physician extenders and peer support providers to address chronic provider shortages.
Transportation	Arrange transportation for the enrollee to the nearest qualified provider.
Long Term Strategy	**Description**
Enhanced Reimbursement	Negotiate enhanced provider reimbursement for weekend, evening and off-hours care, which encourages care at sites other than the ED. **In our Florida Medicaid market, this strategy has resulted in potentially preventable admissions that are 45% lower than expected for calendar years 2019 and 2020.**
Guaranteed Access	Work with providers such as FQHCs, BH providers, and PCPs to identify "guaranteed access" appointment times and expanded access to office hours for our enrollees.
Provider Associations	Collaborate with State and local provider associations (Louisiana State Medical Society, Louisiana Hospital Association, and the Louisiana Association of Nurse Practitioners) to identify potential recruitment targets.
Referral Targets	Work with PCPs to identify specialty providers they frequently refer to for recruitment.
Existing Network	Continue recruitment of existing Humana network providers to participate in Medicaid.
Provider Support	Encourage and support provider groups to recruit additional providers, including physician extenders, or extend their appointment availability.
Expanded Role of Pharmacists in the Care Team	Pilot a program that includes pharmacists on the Care Management team, which has been shown to improve enrollee chronic disease management, particularly in rural areas. This may require a change in Louisiana's existing licensing and reimbursement policies. We commit to working with LDH and its State partners to identify a path to this expansion.

2.6.8.2.4 Challenges to Developing a Complete Statewide Network

Humana Healthy Horizons in Louisiana's **most significant challenge is that in many areas of the State, there are simply not enough providers to serve residents.** In cases such as Psychiatric Residential Treatment Facilities (PRTFs) and certain subspecialties (e.g., dermatology, pediatric endocrinology), licensed providers do not exist. Louisiana contains numerous Health Professional Shortage Areas (HPSAs) for PCPs: LDH designated 60 of 64 parishes as HPSAs for primary care based on geography (not enough practitioners) or low-income population (lack of access to existing care). Only 25% of the State's BH needs are being met with the current number of providers; all 64 parishes are designated mental health HPSAs. These shortages only exacerbate the health challenges residents are facing, including being ranked 46th in death due to heart disease and stroke; 47th in percentage of obese adults; and 49th in maternal mortality. In Region 5, for example, there is a high prevalence of depressive disorder (28.6%) and a lack of PRTFs, psychiatrists, and psychologists. Similarly, Region 8 has the highest rate of low birthweight babies and lacks a sufficient number of OB/GYNs.

We have designed our network development strategy with an understanding of these provider shortages, particularly in specialties or regions where providers do not exist or where we have already contracted with all available providers. We are committed to ensuring access for enrollees through collaborative arrangements with providers and access to innovative tools and solutions.

2.6.8.2.5 Strategies for Monitoring Compliance with Provider Network Standards

In addition to the network gap identification tools previously described in **Section 2.6.8.2.2** Time/Distance Measurement Tools, Appointment Availability Tools; Secret Shopper Calls, Accessibility Audits, Site Visits, Open/Closed panel measurement tools, we use the analytic tools described in **Table 2.6.8.2-5** to monitor provider compliance with network standards.

Table 2.6.8.2-5: Monitoring Provider Compliance

Analytic Tools	Description	Frequency
Enrollee Surveys	Humana reviews Consumer Assessment of Healthcare Providers and Systems (CAHPS) and BH enrollee satisfaction surveys to identify any enrollee access to care issues.	Annually
Site Visits	We use information from our provider site visits for PCPs and high-volume specialists to assess referral needs and accessibility.	Quarterly
Claims Data	Insights from claims data analysis are an early indicator of access issues.	Ongoing
Network Data	We use internal and external data sources to run advanced SPËD algorithm to identify errors in provider data and directory information.	Ongoing
Out of Network (OON) referrals	We track and trend OON referrals made by the Care Management and UM teams to identify potential network gaps.	Daily
Health Equity Assessment	Humana analyzes the cultural and linguistic needs of our membership and the geographic concentration of these enrollees to ensure access.	Annually
Associate, Provider, Enrollee, and Advisory input	We analyze information from various internal and external sources related to network adequacy, including information provided by individuals and committees.	Ongoing

2.6.8.2.6 Strategies for Recruitment and Retention

We recognize that retention starts with getting the basics right; paying claims accurately and timely. We have designed our comprehensive, high-touch provider services model to allow us to truly partner with providers, meeting the unique needs of Louisianans and supporting providers in the evolution and transformation of their practices. We recruit Humana associates from the communities they serve, leveraging their local knowledge to address recruitment and retention needs and allowing associates to build deep, positive relationships with providers. We prioritize recruiting diverse providers that reflect enrollees' needs (e.g., disability, trauma-informed care) and cultural characteristics (e.g., race, ethnicity, language). We view recruitment as an ongoing process as we continuously strive to improve enrollees' access. We highlight additional core strategies of our recruitment and retention model:

Flexible Contracting Mechanisms: Our strategy focuses on flexible contracting, which includes negotiating enhanced rates above the Medicaid Fee Schedule for providers in areas where we have particular difficulty ensuring access for our enrollees, such as rural parishes in Regions 5 and 9, and for high demand services such as BH. Our flexible contracting strategy also includes a commitment to collaborating with providers to identify ways to improve reimbursement levels more broadly. We are working to identify gaps in the [redacted] his strategy ensures that trained and supported providers deliver an appropriate level of quality care to enrollees. Humana also offers VBP arrangements tailored to individual provider types, as well as provider incentives, including [redacted]

Targeted BH Recruitment Strategy: We leverage our statewide commercial and Medicare networks to identify licensed providers (e.g., psychiatrists, psychologists, social workers, etc.) to supplement this network of specialized providers (e.g., HSDs, ACT providers, MHRAs). **Our goal is to contract with high quality providers who can serve enrollees in the least restrictive setting.** We develop targeted tools to support BH providers, such as a BH Provider Manual section with dedicated content (e.g., claims processing guidance) and a section for BH providers in our Provider Directory with complete and accurate information about BH providers (including BH specialty areas) to facilitate referrals and communication. Our experienced Provider Performance Improvement Advisors offer expert support to supplement providers' understanding of the complexities of providing care to enrollees' multiple health and social needs and billing for Medicaid.

Administrative Simplicity with Deep Local Supports: In 2016 Humana launched its Provider Simplicity strategy, aimed at optimizing provider support and aligning resources, reducing touchpoints, and simplifying the provider experience supported by local Provider Relations Representatives.

High-Performing or Gold Card Status to Top Providers: This program helps us identify providers who exceed evidence-based standards for quality and cost. These providers are allowed to bypass our standard outpatient prior authorization process for several services, improving service delivery and reducing provider abrasion. We piloted this program in our Florida market in 2020 and have observed no increase in corresponding utilization patterns. We will pilot this program in Louisiana upon thorough review of high-performing providers.

> "On behalf of The Carpenter Health Network, we are appreciative of HUMANA's quick response from their Administrative Team during COVID. I was relaying to our CEO how comforting it was to pick up the phone and reach a member of your team to help admit a patient quickly when the patient was outside of the normal referral process. As the state moves into a more COVID aware time period, we are grateful to be partners with HUMANA."
>
> – Wendy Knight, Vice President, Payor Strategies & Contracting, The Carpenter Health Network

Provider Retention Through Superior Execution and Support: The foundation of our provider support model is trust. Our interactive onboarding informs providers of Humana's tools and supports, including strong cultural competency tools, and education and training. We offer extensive BH resources such as how to access, deliver, and bill for telehealth services, and provider directories to share accurate and reliable information. We have made investments to support timely claims payment such as **Claims Code Editor,** which allows users to receive real-time feedback on claims submissions, edit claims, and file corrections; and **Provider Payment Integrity (PPI) Unit Live Line** for all providers as an additional channel to contact highly-trained associates regarding prepayment inquiries, edits, and reviews.

Provider Practice Transformation Support: Humana recognizes that providers often need significant capital to transform their practices to participate in advanced care delivery models or improve efficiencies [redacted]

2.6.8.2.7 Strategies to Ensure Network Meets Multilingual, Multicultural, and Disability Needs

In accordance with **Model Contract Section 2.6**, we will develop a Health Equity Plan that includes a cultural competency and sensitivity plan. The following explains our approach to cultural competency and sensitivity in contracting with providers and providing services to enrollees.

Annual Health Equity Assessment of Enrollee Needs: We use data aggregated from the Census and the Modern Language Association Map to understand the linguistic and cultural composition of the communities we serve. We continually assess the composition of our enrollee population to account for racial, ethnic, and geographic shifts to ensure appropriate access to care for the populations served. Based on the findings, we will translate our member materials into the prevalent (threshold) languages spoken to address the linguistic needs of the Louisiana population. We will pursue the **NCQA Health Equity Accreditation Plus** (transition from the Distinction in Multicultural Health Care, effective July 2022), which, among other things, requires that we assess and track languages spoken by and the race and ethnicity of providers in our networks. Our provider directory, available in English and Spanish, identifies languages our providers speak.

Development of a Culturally Humble and Inclusive Provider Network: Partnerships with providers are critical to improve the health and quality of life for our enrollees, such as those with low literacy levels or English language learners. In addition to recruiting and retaining providers who are representative of

the communities we serve, we provide educational resources to our provider network focused on cultural competency and **cultural humility — the practice of building relationships with enrollees to understand their specific needs**. Humana requires providers to participate in educational training that includes cultural competency and cultural humility upon joining our network and annually thereafter. The orientation and annual educational training includes the following topics on cultural competency: policies and procedures for accessing language assistance, strategies for working with elderly or disabled enrollees, appropriate use of in-person and telephone interpreters, communicating with enrollees with cultural and linguistic sensitivity, and disseminating information on cultural differences and diversity.

Providing Communication Support Services: Recognizing the varied linguistic needs of Louisiana Medicaid enrollees, including non-English speaking and nonverbal enrollees, we take extra measures for their spoken languages and communication abilities. Our translation or interpretation services include more than 200 languages and American Sign Language in-person or virtually. For enrollees who are visually or hearing impaired, we use teletypewriter, braille, and other interventions to facilitate their full engagement in the Case Management process.

Provider Monitoring: Monthly, our Quality Improvement (QI) staff monitors enrollee grievances related to cultural competency, including those regarding language barriers, difficulty communicating with providers, and disability access. When we receive a grievance about a provider, Provider Relations staff addresses it immediately with the provider, which may involve assistance such as helping the provider record an after-hours message in Spanish. If grievances show a pattern indicating a need for focused provider training, our QI team and Provider Relations team collaborate to ensure that we adequately train and monitor providers for improvement. Our provider contracts require providers to treat enrollees without prejudice. [redacted] adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to advance health equity.

2.6.8.2.8 Planned Protocol for Terminating Network Providers Without Cause

Humana rarely terminates providers without cause. We give providers multiple opportunities to resolve any issues that may result in termination for any reason, providing support to providers to avoid termination whenever possible, while also recognizing that enrollee safety and quality of care are paramount. Should we make a termination without cause, we will always consult with LDH, particularly if the provider results in a material change in our network (**Model Contract Section. 2.9.28.2**).

Humana has an established process to respond to network terminations, including terminations of providers without cause. As an initial step, we assemble our Network Termination workgroup to ensure that we consider all aspects of the termination. Next, we will notify LDH in accordance with **Model Contract Section. 2.9.2.0**. We will also develop a **Continuity of Care Plan** on transferring enrollees to new providers while minimizing disruptions in care. Using claims data and provider assignments, we send notices to affected enrollees, notifying them of the situation, assisting them in selecting a new provider or providing information regarding new provider assignment if they do not select, transferring records, recording prior authorizations and standing order information, and making them aware of resources available to them during this period. These resources include support from our Enrollee Services team, Case Managers and CHWs to answer questions and assist with transition to a new provider. We have contingency plans in place to allow enrollees to access out of network providers when necessary until we establish a new in-network provider relationship. Humana allows all pregnant enrollees and enrollees in active treatment to continue with their provider until completion of postpartum care or the end of active treatment (up to 90 days or as long as required by law).

Humana sets up a table at the Makin' Groceries event, July 23, 2021. Associates were on hand to share giveaways and answer questions about the available services. Humana sponsors the Makin' Groceries Mobile Market, improving access to food and essential resources in rural communities across Acadiana.

Section 2.6.9

Provider Support

Humana

Healthy Horizons™
in Louisiana

2.6.9 2.6.9 Provider Support

Humana Healthy Horizons in Louisiana has reviewed and confirms adherence to requirements in **Model Contract Section 2.10**.

2.6.9 Ensuring Timely Payment and Appropriate Support over the Course of the Contract

Founded in 1961 as a provider organization, Humana focuses on the fundamental business of supporting providers in transitioning to a new Medicaid Managed Care Organization and improving quality of care. Our 2021 Louisiana Medicare 4.5 Star rating in 2021 and our 36 years of experience supporting **approximately 19,300** Medicare, Commercial, and TRICARE providers serving more than 450,000 enrollees in all nine regions places us in a leading position to serve Louisiana's Medicaid enrollees. We will leverage this experience to deliver high-quality care to Healthy Louisiana Medicaid enrollees through our Provider Engagement Model (described in **2.6.9.9**). Our Provider Engagement Model drives our provider support strategy, which promotes administrative simplicity through a single point of contact for our Medicaid providers, supported by regionally dispersed Medicaid-dedicated staff. Our staff ensures that providers achieve timely claims processing and payment while **helping them improve quality and performance** through comprehensive data analytics tools. We achieve provider satisfaction through timely and responsive communication and supports on topics such as integrated care. This enhanced and tailored provider education and training enables providers to advance along the value-based care continuum.

In 2001, Humana co-launched the Availity Multi-Payer Provider Portal to simplify the provider experience and streamline processes among payers. This one-stop shop for claims submissions, disputes and appeals forms, eligibility and benefits verification, authorizations and referrals, and more allows providers to access enrollee information across all payers through a single sign-on. This self-service tool will have a customized page for Louisiana Medicaid providers to communicate with all payers in real time and access tailored education programs.

Humana is committed to supporting specialized behavioral health providers through:
- **Customized training** to promote integrated care
- **Dedicated staff** to assist with BH-specific claims issues and enable practice transformation
- **Tailored VBP arrangements** to help providers reduce costs and improve quality

2.6.9.1 Determining Adequate Provider Relations Staffing Coverage for Provider Network

Humana follows a comprehensive process for determining adequate provider relations staffing coverage:

Assess the Network: Humana's process begins with **assessing our local provider network**. Assessment activities consider the number of each provider type within each region, provider location (rural vs. urban), readiness for value-based purchasing (VBP), communication, meeting frequency preferences, number of providers per location, utilization patterns (e.g., claims history), the complexity of enrollees, and number of visits projected for each type per year. Our experience shows that our **local dedicated Medicaid Provider Relations Representatives** (described in **2.6.9.10**) spend one to three hours per visit on average, including travel time, meeting time, and follow-up time.

Provide Local Support and Address Provider Issues: [redacted] described in **2.6.9.10**, we hire from our local provider communities and disperse this team throughout all nine regions. Their understanding of the provider issues and cultural nuances within each region helps them build strong provider relationships with providers including, but not limited to, federally qualified health centers (FQHCs), small and rural providers, and specialized behavioral health providers. For example, we recognized that enrollees struggled to schedule timely BH appointments, and primary care providers (PCPs) were challenged with

behavioral health referrals due to access issues. We collaborated with a group of targeted PCPs and behavioral health providers to create familiarity and understanding, providing PCPs a list of behavioral health provider contact information, and the behavioral health consult and behavioral health crisis lines. This improved the likelihood of PCPs referring enrollees to behavioral providers and led to developing a co-location strategy including telehealth.

Monitor Trends and Provider Feedback: Through our Louisiana provider relationships, we will **monitor trends and provider feedback** to determine additional staffing needs. We will continuously monitor our membership and provider network counts to determine staffing needs by viewing claims usage, claims denial, prior authorization, complaint trends, and the number of providers participating in VBP. We adjust staffing accordingly, considering specific needs for individual provider types. For example, we assign Provider Services team members to specialized behavioral health providers, rural health providers, and FQHCs to ensure custom support.

[redacted]

2.6.9.2 Providing Effective and Timely Communications with Providers

Our effective and timely communication strategy includes building strong provider relationships using tailored education, outreach, and support. We train provider-facing teams to support individual providers' specific needs, working closely to build trust and accountability to simplify the provider experience. **Our high-touch approach keeps providers informed of processes and policies, supports them in improving quality and progressing along the VBP continuum, and delivers customized training**.

Our Louisiana Medicare Provider Relations team conducted **more than 9,000 provider visits** in 2020.

Communicating Effectively and Timely with Providers

Provider communication begins with our onboarding strategy, which outlines how to do business with Humana while also gathering feedback on how best to communicate with individual providers. This strategy allows us to create a customized experience for each provider through interactive and on-demand methods.

We provide interactive communication through regular provider meetings, town halls, committees, and email. **Dedicated Medicaid provider-facing field staff** meet regularly with PCPs, hospitals, specialized behavioral health providers, specialists, and ancillary providers to communicate plan updates, provider performance, integrated care, claims issues, and more. We also communicate via virtual and in-person

regional town halls, and through our **Provider Advisory Council, its Behavioral Health subcommittee**, and our **National Provider Committee**. **Secured email** allows physical and behavioral health providers to submit rosters and receive responses within five business days.

> "From day one I could tell that Felton was sincerely interested in helping both the patient & PCG Medical...I am so grateful not only Felton's competence but his incredible drive to help his providers & get results so we can help the patients we serve. Thanks a million!!!!!" - Micheline Stephens, PT, PCG Medical

We provide on-demand communication as follows: Our **provider website** gives 24/7 access to Medicaid materials and includes updates such as state of emergency notices and quality initiatives (e.g., annual checkups and breast cancer screenings). [redacted] In accordance with **Model Contract Section 2.10.5**, our provider website includes the provider handbook, behavioral health services provider manual, provider newsletters, provider training manual, prescription drug guide, and Louisiana Medicaid preferred drug lists. Our custom **provider portal** allows providers to check claims and prior authorization status, live chat with Provider Relations Representatives, and give feedback via satisfaction surveys. In fall 2021, providers will have the ability to initiate claim disputes and appeals and check status through the provider portal. In accordance with **Model Contract Section 2.10.3.7**, a toll-free **Provider Call Center** has Louisiana-based associates who will be trained on Louisiana's Medicaid Program and able to address physical and behavioral health provider issues Monday through Friday from 7 a.m. to 7 p.m. Central time. They take messages for nonemergent issues and deliver them to Provider Relations Representatives if they are not immediately available. The Call Center uses interactive voice response technology to manage nonroutine prior authorization requests 24 hours a day, seven days a week. **Our Behavioral Health Crisis Hotline** and **Utilization Management Call Center** are available 24 hours a day, seven days a week for emergent provider issues and enrollee emergencies.

Developing a Provider Education Program

> Over the past five years, **100%** of our Florida and Kentucky Medicaid providers have received their orientation within 30 days.

Humana offers frequent, ongoing provider education through multiple channels to simplify the provider experience, as detailed in **Figure 2.6.9.2** and our QAPI Provider Support Plan. Our provider education program complies with **Model Contract Section 2.10.7**, including required onboarding training and an extensive selection of optional tailored training for providers and their staff. We have structured a flexible, scalable provider education program to support providers' varying knowledge bases, needs, and learning styles, allowing providers to complete training at their own pace and in the manner they prefer.

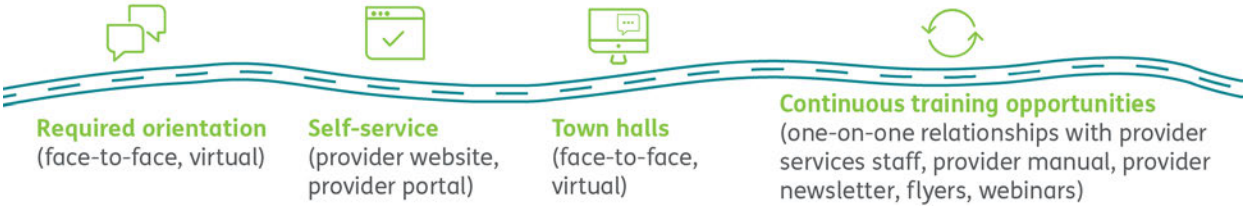


Figure 2.6.9.2 Provider Education Journey

Required Orientation: Our Provider Relations Representatives offer all new providers **onboarding training virtually or in-person** on topics including but not limited to LDH and Medicaid requirements, health equity, social determinants of health (SDOH), integration, claims submissions, cultural competency, telehealth, covered and noncovered services, VBP participation, [redacted]

[redacted]

Self-Service: **self-service tools** provider portal and website) during onboarding, which offer more than 300 eLearning Library courses through web-based training on topics including integrated care, behavioral health screenings in the primary care setting, COVID-19-related trauma, and business ethics, and more. At this time, Provider Relations Representatives discuss provider goals and create a proposed individualized training curriculum to help reach their goals.

Town Halls: Upon completion of readiness review, **we will conduct in-person and virtual town halls in all nine Louisiana regions** and ongoing virtual town halls as needed following implementation to educate providers on topics including integrated Care Management, provider resources, collaboration opportunities, and more. We will hold breakout sessions for specific topics, such as high claims denials. We propose conducting collaborative town halls with other MCOs and the Louisiana Primary Care Association.

Continuous Training Opportunities: Our Provider Relations Representatives work closely with providers to identify additional and **continuous tailored training opportunities**. For example, if a provider has a claims issue, they refer them to a Provider Claims Educator (described in **2.6.9.10**). Our Louisiana Medicare team holds weekly webinars on obtaining authorizations, resolving claims, "Making It Easier" claims training, and prior authorization lists. Ninety providers have participated. We will offer similar biweekly webinars specific to Medicaid. We continuously enhance our provider education program based on new contract requirements, and provider and enrollee feedback including the Provider Advisory Council and Enrollee Advisory Council. In addition, providers complete surveys at the end of the "Making it Easier" webinars. This feedback helps us enhance the quality and content of the education series.

We will partner with NAMI to offer all Louisiana Medicaid providers health equity training and a free Mental Health First Aid course.

As part of our continuous training opportunities, our dedicated behavioral health Provider Relations Representatives work with **specialized behavioral health facilities and agencies** to develop a curated education program that fits their needs. Training addresses administrative and clinical aspects of integrated services, such as billing and claims, PCP referrals, and meeting quality measures**. Mental Health First Aid training provided by NAMI includes trauma-informed care education to address post-traumatic stress disorder (PTSD) conditions and behavioral health providers** can select from topics on integrated care, including:

- Integrating Primary Care and Behavioral Health
- Integrated Treatment Planning
- Serious Mental Illness (SMI) and Respiratory Disease
- Addressing Obesity in Individuals with Mental Illness

- Making Referrals to a PCP
- Integrated Treatment Planning
- Overview of Diabetes Care for Behavioral Health Professionals
- Post-Traumatic Stress Disorder Including Related to Natural Disasters
- Treatment for Substance Use Disorder
- Trauma-Informed Care

Humana will use the Substance Abuse and Mental Health Services Administration (SAMHSA) Health Resources and Services Administration's Integrated Practice Assessment Tool results and ongoing provider feedback to continuously add relevant integration training and education topics to our curriculum.

90.2% of Humana claims were adjudicated automatically in 2020.

2.6.9.3 Supporting Providers with High Claims and Denial Rates

Humana's claims strategy goal is to *pay it right the first time*. We take a proactive approach to minimize claims denials through **education and training**. Regional Provider Claims Educators conduct live trainings for claims denials or underpayments related to provider complaints. Provider Claims Educators work with internal teams to monitor providers post-training to ensure the issues causing the denials are resolved. Provider Claims Educators monitor for recurring issues and conduct root cause analyses, identifying areas of improvement. Our virtual and one-on-one on-site strategy promotes use of our claims tools and educates on common errors to improve claims submission accuracy. Provider Relations Representatives reach out to new providers at Contract go-live and regularly thereafter to familiarize them with our tools and trainings. **Provider Claims Educators work closely with our Provider Relations Representatives and internal teams to conduct targeted training for providers and their staff to address high rates of claim denials or patterns of denied claims we identify via root cause analysis**.

Our Claims team **identifies providers with high claims denials and conducts root cause analysis** in our Claims Adjudication System. Those with denial rates of 10 percent or higher are flagged and automatically undergo clinical review to determine denial cause. Their Provider Relations Representative arranges support from our Provider Claims Educators. Our teams flag providers with denial rates from 2 to 10 percent to offer help and education. Our Claims team works with the associates managing our code edit and claims testing tools to assess the need for corrections.

In 2020, in an average month, we paid 98.5% of our Florida claims (non-skilled nursing facility, non-hospice) on first pass and within 15 days.

To avoid denials, we create tools like our **Code Edit Simulator**, which provides real-time feedback on simulated claims submissions and allows providers to edit claims and file corrections via our **provider portal**. This tool will determine if our claims edits are not working correctly or if a system issue exists. If a system issue is present, we reprocess claims. We encourage electronic claims submission via direct data entry form on our provider portal, significantly reducing the likelihood of a claim denial. Due to targeted outreach encouraging providers who submit paper claims to submit electronically, **77% of Humana providers currently submit electronic claims.**

2.6.9.4 Evaluating and Resolving Provider Disputes in a Timely Manner

In accordance with **Model Contract Sections 2.10.9 and 2.18.12**, Humana maintains a comprehensive provider disputes program designed for swift and thorough resolution. Our goal is accurate and timely resolution of all provider disputes regardless of how they are submitted (in person, phone, email, mail, fax, or provider portal) to maintain strong provider partnerships. **Our operational teams ensure**

compliance with time frames and focus on the root cause of disputes through real-time monitoring for emerging trends.

Evaluation: In accordance with **Model Contract Section 2.10.9.5.2**, we manage in-network and out of network provider disputes through [redacted], a Provider 360 Subcommittee, and an online disputes form on the provider portal. After dispute resolution, data are collected, analyzed, trended and root cause details are reviewed with operational teams. We implement improvement action plans and an oversight committee monitors progress.

In 2021, 99% of our Florida Medicaid providers surveyed were satisfied with our provider materials.

Education and Notification: We use multiple channels to educate providers on our provider disputes system and to interact with them as they navigate it. Our Provider Services team includes specially trained experts who track and research complaints, including claim disputes and those related to PCP assignment, using our end-to-end inventory management system, which is built to process disputes consistently, within LDH's mandated time frames. This team educates providers on how to file a complaint and the difference between an enrollee grievance and a provider complaint. Grievances and appeals filed by a provider on behalf of an enrollee are routed to our Grievance and Appeal team for resolution. Within three business days of receipt of a complaint, the Provider Resolution team, which reports to the Provider Services Director, notifies the provider in writing that the complaint has been received, then researches the complaint, reaching out to the provider as necessary for additional information.

Resolution and Reporting: Following their research, the Provider Services team resolves the complaint in accordance with statutory, regulatory, contractual, provider network agreement provisions and **Model Contract Section 2.10.9.8.** We have a process to escalate issues to our Chief Operating Officer and Chief Executive Officer in accordance with the MCO Manual. Within 30 days (15 days for disputes related to PCP assignment), the Provider Resolution team completes the review and sends the provider a resolution letter informing them of the decision and escalation procedures as applicable. **We report all provider disputes to LDH monthly.**

Evaluating and Resolving Provider Disputes Regarding Enrollee Assignments

In accordance with **Model Contract Section 2.9.11.3.3**, Humana has processes to ensure effective enrollee assignment and align costs with the appropriate provider. We work proactively to minimize disputes by reaching out to enrollees to encourage them to select a PCP and running our claims based attribution model monthly. If we identify that enrollees are consistently using another PCP for evaluation and management or wellness services, we will reach out to enrollees to encourage selection of the PCP providing services as determined by our claims analysis and attribution processes. We will also perform root cause analyses to see if any changes are needed to our PCP auto-assignment algorithm. Providers can see any changes to their rosters through our provider population health platform, **Population Insights Compass**.

Despite these efforts, we know disputes can still occur and we are poised to swiftly address them. Providers can submit enrollee assignment disputes through our online disputes form, their Provider Relations Representative, and our Provider Call Center. When a dispute is submitted, the Provider Resolution team conducts root cause analyses to identify if enrollee PCP assignment or VBP attribution need to be adjusted, including review of enrollee's previous claims utilization patterns, and makes any necessary adjustments. **We will respond to all disputes within 15 calendar days per LDH requirements.**

2.6.9.5 Supporting Providers to Improve Quality and Reduce Costs through Reform Strategies

Humana's strategies to **support providers in delivery system and payment reform** include:

- Robust Provider Engagement Model that includes a Medicaid-dedicated team of associates experienced with specialized provider types (described in **2.6.9.10**)
- Provider education, training, and practice transformation
- Commitment to VBP across all provider types, as transitioning payment away from volume is key to helping providers deliver higher quality care and manage costs
- Comprehensive suite of data analytics tools (described in **2.6.9.8**)

We customize these strategies for PCPs, behavioral health providers and other specialty providers, as described in **2.6.9.6** and **2.6.9.7:**

2.6.9.6 Strategies to Support Primary Care Providers

In 2020, **100%** of Humana Kentucky Medicaid provider satisfaction survey respondents reported that PCPs 'always' or 'often' send the specialist the patient's history and reason for consultation.

We support PCPs through practice transformation, infrastructure investments, value-based opportunities which offer enhanced rewards and more flexible reimbursement mechanisms that better align with patient-centered medical home care delivery through our **Advanced Primary Care (APC) Model**. Our APC model is open to all PCPs, which gives them: access to practice transformation resources to enhance capabilities including telehealth and integrated care capacity; insight into quality and performance improvement opportunities; assistance with referrals to help address SDOH; and support with care coordination and integrated care efforts to help treat behavioral health and complex conditions. Provider Performance Improvement Advisors help providers improve quality and VBP performance including conducting VBP readiness assessments. Our Practice Transformation Specialists help PCPs advance and improve quality, care coordination, population health management, and integration capabilities that will help them succeed in delivering high-value, high-quality care through network-wide education and **practice coaching**. Providers that require financial assistance can use the Practice Transformation Fund to purchase telehealth equipment, hire additional staff including interpreters, set up electronic health records, and more.

Humana has made substantial **investments in primary care infrastructure for Medicaid-eligible adults**. Our **partnership with Ochsner Health System to build three clinics** (in medically underserved areas with limited access such as Shreveport and Monroe) will deliver integrated care to Medicaid-eligible adults via both on-site physical and behavioral health providers, provide care management, and act as an access point for SDOH supports. Further increasing access to care where behavioral health and pediatric providers are limited, we will offer regional mobile clinics to provide exams, screenings, vaccinations, bloodwork/labs, telehealth, and potentially serve as disaster recovery locations.

[redacted]

2.6.9.7 Strategies to Support Behavioral Health and Other Specialty Providers in System Reform Activities

We have targeted strategies that consider the contracting, billing, and structural nuances of behavioral health and other specialty providers. Our Louisiana based Medicaid Provider Services staff is structured to promote mental health parity, with **behavioral health-dedicated Provider Contracting staff and behavioral health-dedicated Provider Relations Representatives and Provider Performance**

Improvement Advisors. They collaborate to ensure behavioral health providers of all types, including Human Services Districts and large inpatient hospitals, which vary considerably in their capabilities and support needs, experience a smooth transition to a new Medicaid Managed Care Organization and receive the support they need to deliver high-quality care. This staff offers custom virtual and in-person individual and group training to help providers navigate Medicaid Managed Care Organization processes and available services, and specialized training such as Screening, Brief Intervention, and Referral to Treatment.

We offer **integrated care support** through a psychiatric consultation line; behavioral health billing support; and The Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration's Integrated Practice Assessment Tool to assess provider readiness to participate in integration and facilitate integration continuum advancement. Our Practice Transformation Specialists help behavioral health providers and OB/GYNs improve quality, care coordination, population health management, and integration capabilities. [redacted]

2.6.9.8 Strategies to Share Provider Performance Data in a Timely and Actionable Manner

Our Medicaid Provider Services team collaborates to provide timely reporting to providers on their performance in quality and VBP programs. Staff provides ongoing education and support to help providers understand the reports we give them and develop specific action steps based on performance data, delivering reports in-person or electronically depending on provider preference. They leverage the following tools to provide performance data:

Clinical and Cost Data Analytics for Providers

Our provider population health platform, **Population Insights Compass,** takes all financial data (medical/pharmacy claims, encounters, service fund settlement, rewards), and clinical data (care gaps, census and clinical programs, labs, electronic medical records, predictive models and clinical interface), and creates custom reports including Care Gap reports, emergency department visits, pharmacy reports, Census reports, Patient Detail reports, and a Key Performance Indicator dashboard to help track provider performance.

[redacted]

Provider Performance Improvement Advisors help providers digest all of this available data analytics into concrete opportunities for them to improve their quality metric performance, close care gaps, and succeed in their VBP arrangements.

Physician Performance Ratings

Care Decision Insights provides PCPs with information about specialists' quality and efficiency in their region to help PCPs make more informed referrals. Care Decision Insights provides ratings based on effectiveness and efficiency, allowing specialists to compare their performance and costs to their peers.

Care Highlight displays provider clinical quality and cost-efficiency ratings on Humana's provider directory, 24/7 in accordance with **Model Contract Section 2.10.2**. These ratings provide information on

provider performance, enabling enrollees to make more informed decisions when seeking care, and promoting utilization of high-quality providers.

Self-Service Tools to Access Data and Information

Our **provider portal** is available 24 hours, seven days a week and allows practices to access key information including referral reports; authorization forms and approvals; enrollee admissions, discharges, and transfers; and claim status. Humana's Care Profile application in our Provider Portal enables providers to view attributed enrollees' contact information, assessments, and care plans (with appropriate enrollee consent).

Seamless real-time medical record sharing between providers and our Care Management teams is available through our direct connection with **Electronic Health Records**. We committed to connect with the **Greater New Orleans Health Information Exchange** to increase connectivity to FQHCs and leverage the **Corrections-Community Care Continuum**. Based on discussions with **Health Sync**, which is establishing health information exchange capabilities in Louisiana, we plan to build data exchange partnerships with providers throughout the state.

2.6.9.9 Provider Engagement Model

Our Provider Engagement Model is based on broad experience in our Medicaid markets and feedback from associates and providers. It delivers high-touch support for Medicaid providers via [redacted] Through our Provider Engagement Model, we intend to leverage our 36 years of experience building trusting relationships with Medicare and Commercial providers in Louisiana as we support Louisiana Medicaid providers in transitioning to a new Managed Care Organization.

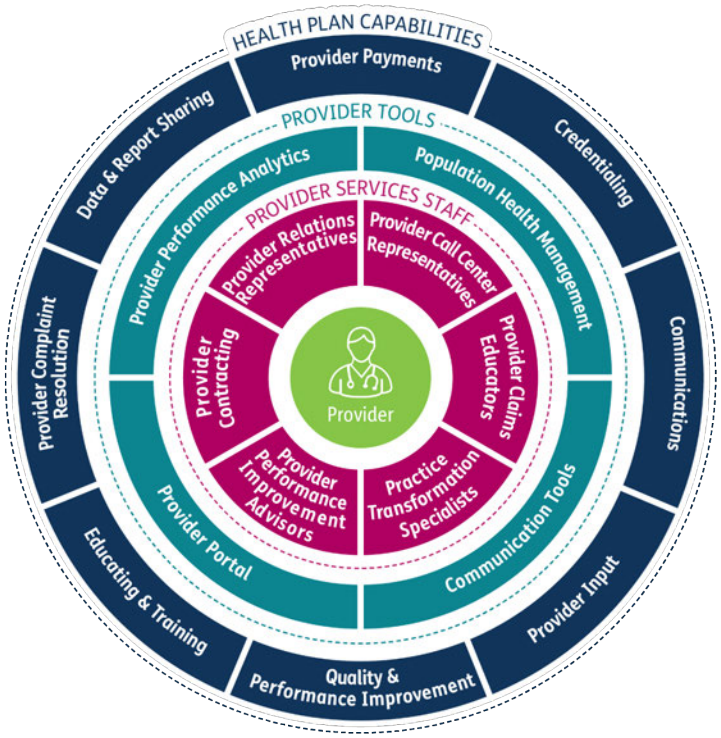


Figure 2.6.9.9 Provider Engagement Model

2.6.9.10 Provider Engagement Staff

Our Provider Services Manager, [redacted], leads our Provider Engagement staff, listed in **Table 2.6.9.10**.

Table 2.6.9.10 Provider Engagement Staff

Staff	Area of Responsibility
Medicaid Provider Relations Staff	Regional **Provider Relations Representatives** specially trained to support individual provider types including, but not limited to, FQHCs, rural health clinics, behavioral health providers, and facilities and ancillary providers. Manage all administrative matters including onboarding, education, facilitating prior authorizations, and facilitating claims and complaint resolution by connecting providers to experts in those areas.
	Regional **Provider Claims Educators** help resolve claims quickly and perform claims analysis and trending to identify the need for system improvements or additional provider training. Educate providers on claims payment processes and provide tools to help limit claims errors.
Medicaid Provider Performance Improvement Staff	Regional **Provider Performance Improvement Advisors** provide quality improvement and VBP support for individual provider types including PCPs, FQHCs and rural health clinics, behavioral health specialists, Human Services Districts, OB/GYNs, and specialists; collaborate with providers, assessing provider readiness for VBP arrangements and sharing quality and performance data using [redacted]
Medicaid Practice Transformation Staff	**Practice Transformation Specialists** collaborate with providers to build and strengthen their practice capabilities to deliver comprehensive care to enrollees and participate in more advanced VBP models. Provide specialized education and technical assistance.
Quality Staff	**Quality Associates** review behavioral and physical health provider records to ensure proper documentation of care delivery, identify opportunities to improve the documentation and delivery of treatment; and proactively engage with providers continually to review records using a standardized tool with core-required elements. Educate on proper documentation, and flag any significant quality of care findings for further investigation and follow-up.

Our Provider Engagement staff is supported by Provider Services including local Provider Call Center Representatives who are cross-trained to handle all telephonic inquiries from physical and behavioral health providers, and various departments throughout Humana, including local Provider Contracting Representatives who engage, recruit, and support physical and behavioral health providers through the contracting process; Provider Resolution associates who quickly resolve provider disputes; Quality associates who provide quality data support; Case Managers who support enrollees with chronic conditions; Community Health Workers who connect enrollees to community supports; and Virtual Embedded Associates, Humana staff who are available for remote support and refer enrollees to social supports such as transportation, healthy food, housing, and childcare.

2.6.9.11 Local Provider Field Representatives and Their Role

Our regional Medicaid Provider Relations Representatives live in, work in, and represent the communities we serve, delivering in-person support in all nine Louisiana regions. Provider Relations Representatives receive extensive training prior to Contract go-live and our annual **Perfect Experience associate training** so they can effectively help providers transition to a new Managed Care Organization and deliver ongoing support to improve enrollee health outcomes. They are specially trained to work with individual provider types including FQHCs, rural health clinics, behavioral health providers such as Human Services Districts, OB/GYNs and specialists.

> "I wanted to ensure that you know, on behalf of The Carpenter Health Network, we are appreciative of HUMANA's quick response from their Administrative Team during COVID. I was relaying to our CEO how comforting it was to pick up the phone and reach a member of your team to help admit a patient quickly when the patient was outside of the normal referral process. As the state moves into a more COVID aware time period, we are grateful to be partners with HUMANA. Thanks again!"
> – The Carpenter Health Network

As the **single point of contact for providers, these local Provider Relations Representatives build strong relationships and simplify the provider experience**. This starts with onboarding, in which they educate providers on how to work with Humana; introduce them to self-service tools such as our Provider Portal;

introduce them to resources such as the provider website that includes the provider manual and provider newsletters; and provide extensive education in person and virtually as described in our response to **2.6.9.2**. Ongoing, Provider Relations Representatives meet providers regularly to educate and discuss administrative matters. They connect providers to other experts as needed, such as those who facilitate claims and complaint resolution. They also connect providers with their assigned Provider Performance Improvement Advisor for quality improvement and VBP support, and Practice Transformation Specialists for practice transformation assistance.

2.6.9.12 Mechanisms to Track Interactions with Providers

Our streamlined processes track distinct provider interactions, including:

Electronic Interactions: We track every interaction our providers perform in our provider portal noting which providers access the site and the tools they access. Providers use our other web-based tools, (e.g., online training modules), which we track to ensure information is accessible and compliant with training requirements. **Humana's Medicaid provider websites received more than 68,000 views in 2020.**

Physical Interactions: We track all administrative and clinical visits by Provider Relations Representatives, Provider Performance Improvement Advisors, and Provider Claims Educators, which drive future interactions. Our visit checklists allow Provider Relations Representatives to track provider interactions including claims experience, action items, and follow-up meetings.

Telephonic Interactions: Our Provider Call Center and Provider Relations Representatives log call topics and outcomes, routing and escalating (if needed) through our Customer Relationship Management tool to the appropriate associate for resolution. We identify, track, and trend for root cause analysis to resolve concerns, recording the full interaction in our Customer Relationship Management tool for reporting purposes, including response resolution time. These processes enable interaction data to be loaded and stored for trend analysis and improvement. Our Provider Services leadership, Provider Advisory Council, and Provider 360 Subcommittee review reports related to all interactions to identify broad training needs including specific code edit training or targeted training on topics specific to a provider type or geographic area, and provider interaction improvements.

Our Medicaid Provider Call Center associates provided accurate information to providers 96% of the time in 2020.

2.6.9.13 Collecting and Analyzing Utilization Data and Provider Feedback

We collect and analyze utilization data and provider feedback regularly to identify opportunities for improvement and additional training.

Collecting Utilization Data: Our data systems proactively monitor for medical, behavioral health and pharmacy over- and under-utilization such as, frequency of procedures, emergency department visits, prescribing trends, and inpatient measures from Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. Our dashboard reports, which monitor utilization at the population and enrollee levels, provide skilled associates with actionable data to identify enrollees who are at high risk for high-cost or over-utilizations of services.

Collecting Provider Feedback: We collect provider feedback through: One-on-one visits; committees including the Provider Advisory Council, Community Advisory Board, Medicaid Advisory Panel, Joint Operating Committee, and Health Advisory Committee; stakeholder meetings; regional town halls; surveys and more. **Through our provider support, 98% of our Florida Medicaid providers surveyed in 2021 reported they were satisfied with our claims submission process.**

In a blind, Humana-commissioned survey administered by a third-party research firm over 2020 and 2021, Humana earned the second-highest Net Promoter Score among major competitor payers from a random sample of Humana primary care physicians in Louisiana.

Analyzing Utilization Data and Provider Feedback: The actionable utilization data and provider feedback is shared with our Provider Services, Provider Network, and Quality Management leadership and through our internal committees including the Provider 360 Subcommittee, Technical Advisory Committee, and Quality Improvement Committee, who monitor provider performance trends and identify additional needed training and corrective action. Our Provider Services team meets weekly to identify root causes, discuss issues and resolutions, and initiate provider notifications and potential resolution and remediation which include provider alerts, on-site visits by field staff, provider or clinical leadership, or quality improvement plans.

2.6.9.14 Metrics to Measure Satisfaction of Network Providers

Humana uses a variety of methods to obtain metrics to measure the overall satisfaction of network providers in order to identify trends and opportunities for improvement. These methods and metrics align with **Model Contract Section 2.10.8.3**, will be reported to LDH as required, as listed in **Table 2.6.9.14** and include:

Table 2.6.9.14 Metrics to Measure Satisfaction of Network Providers

Method	Metrics	Resulting Improvements
Provider Satisfaction Survey	Annual survey to measure satisfaction with access to linguistic assistance, training, communication, claims processing, dispute resolution, and coordination of care.	Improvements to Provider Portal including developing Code Edit Simulator, Total Humana Overpayment Resolution (THOR), and Provider Payment Integrity Unit Live Line.
Provider Relationship Tracker Survey	Semiannual national survey includes Net Provider Score (NPS) questions that ask providers whether they would recommend Humana to other providers.	2020 surveys measured an NPS improvement of 6 points, a decrease in the incidence of submitting medication authorizations, and an increase in satisfaction with timeliness and issue resolution.
Voice of the Customer Survey	Surveys providers who call our Provider Call Center and Provider Payment Integrity Resolution team on likelihood to recommend Humana to a colleague, associates' ability to assist provider, ease of communication, and overall call experience.	Development of a timely filing calculator for Call Center associates to help calculate the timely filing limit, advise whether a claim was denied for timely filing is the appropriate outcome, and help determine if a claim was denied in error.
Provider Complaint Reporting	Claims denials, incorrect claims payments, reimbursement rates, prior authorizations, provider enrollments, credentialing, etc. reported to the State monthly.	Complaints about transportation vendor resulted in new transportation monitoring system including daily calls for urgent issues, biweekly calls to review grievances and trends, and monthly meetings to review and address overall performance data trends.

2.6.9.15 Provider Training on Humana and Louisiana Medicaid Managed Care Program

Humana will offer the following comprehensive training on Humana Healthy Horizons in Louisiana and Louisiana Medicaid Managed Care Program requirements in a variety of formats, detailed in **Table 2.6.9.15:**

Table 2.6.9.15: Approach and Frequency of Training

Training	Frequency
Initial Training including basic Medicaid program requirements (in-person and virtual)	Within 30 days of contracting in compliance with **Model Contract Section 2.10.7.1**
Regional Town halls: In person and virtual	During implementation; at least annually thereafter
Annual Policies and Procedures training (in-person and virtual)	Annually
Program Specific Training (High-claims denials, service authorizations, Level of Care Utilization System, Office of Behavioral Health standardized training, step therapy, etc.) (in-person, virtual and online)	As needed
Webinars: Online	Biweekly, monthly, on-demand

Kingsley House Head Start program: Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

Section 2.6.10

Utilization Management

Humana

Healthy Horizons™
in Louisiana

2.6.10 2.6.10 Utilization Management

Humana Healthy Horizons in Louisiana has reviewed and confirms adherence to the requirements in **Model Contract Section 2.12**. Our written Utilization Management (UM) program policies and procedures, structures, and processes meet NCQA standards.

In April 2020, Humana was the **first Florida Medicaid plan** to suspend all inpatient prior auth requests to provide financial and administrative relief for the healthcare and provider community facing unprecedented strain during the COVID-19 pandemic.

2.6.10.1 Satisfying Service Authorization Requirements

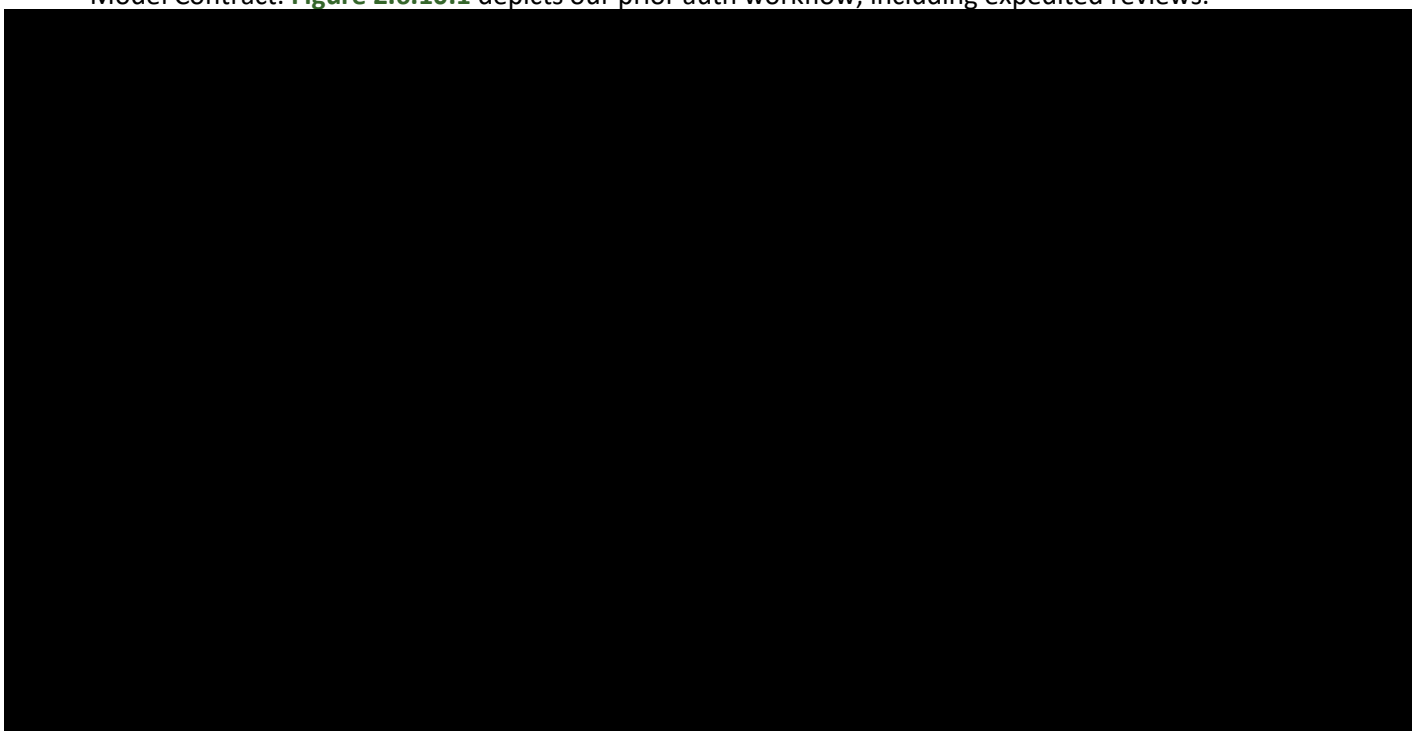
Humana's robust prior authorization (prior auth) systems and automated processes reduce provider burden and ensure timely and appropriate delivery of enrollee care. Our systematic processes help us consistently adhere to required time frames. **Since 2021 began, we have processed more than 400,000 prior authorizations in our Florida and Kentucky Medicaid markets, achieving a compliance rate with required time frames of over 99.7% in both markets.**

Processing Service Authorization Requests

We use specific metrics to determine whether to include a service in the prior authorization list (PAL) while adhering to State guidelines. These metrics include current over-, under-, and inappropriate utilization; potential quality of care concerns; trends of services not meeting nationally recognized evidence-based criteria for medical necessity; claims volume for a service; projected enrollee impact; and projected provider impact. We convene cross-functional departments across our market-based team, as well as representatives from our provider network, to review and analyze trends and utilization, financial, and quality metrics on an ongoing and annual basis. This is to ensure our PAL meets the evolving needs of our enrollees. **Humana will seek to lead efforts to convene the other selected managed care organizations (MCOs) to coordinate our PAL and prior auth processes across plans to reduce provider administrative burden. We will include provider representatives across specialties and geographic regions in these conversations to promote transparency and collaboration.**

Proposed Workflow

Designed to ensure timely, efficient, and effective care, our prior auth processes fully comply with the Model Contract. **Figure 2.6.10.1** depicts our prior auth workflow, including expedited reviews.



Prior Authorization Submission Processes Promote Enrollee and Provider Ease

Humana allows enrollees and providers to submit prior auths 24 hours a day, 7 days a week through a variety of mechanisms. Enrollees may submit a written request via mail or call our dedicated Clinical Intake Team (CIT). Providers may submit prior auths through any of the following:

- **Online**: Providers may submit and upload supporting clinical documentation through our provider portal, **Availity**. Once submitted, the request routes through our logic-driven processes within our clinical workflow system.
- **Phone, Email, and Fax**: Humana's dedicated, 24/7 CIT is our primary point of entry for phone, email, and fax requests. Calls into our Louisiana-based Provider Call Center regarding prior auths are directly routed to our CIT for specialized support.

Innovative Approaches to Reduce Provider Administrative Burden

Humana employs a multifaceted approach to reduce provider administrative burden via our UM processes which promote timely and seamless delivery of appropriate enrollee care. **Humana has partnered with Epic to enable automated prior auths and enrollee insights at the point of care**. Enhanced features allow the clinician to remain in current workflows when ordering procedures, without switching systems or screens, **enabling true interoperability** and reducing the time it takes providers to determine whether a service is covered. [redacted] Upon analysis, the provider is scored to determine if they meet criteria to receive Gold Card status. In a 2020 pilot in our Florida market in 2020 with two provider groups we observed no increase in corresponding utilization patterns. We will pilot this program in Louisiana upon thorough review of high-performing providers.

Interfacing with the Single Pharmacy Benefits Manager

We look forward to working with the State's single pharmacy benefits manager (SPBM) on administrative and payment services and will tailor our processes to meet contracting needs. Humana will assist providers in connecting to the SPBM and will use the daily claims file to manage medication therapy management, our Louisiana lock-in program, enrollee management, and retro DUR programs and processes in compliance with the requirements outlined in the **MCO Manual**.

Multi-Pronged Approach to Ensuring Timely Processing

Robust UM System Automatically Ensures Adherence to Timeliness Requirements

Our automated internal UM processes use logic-driven programming to adhere to timeliness requirements. Automated features that support timely UM activities include:

- Routing of authorizations with date and time stamps within system
- Automated business rules route in real-time to appropriate clinical team for review
- Auto-approvals of requested services that do not require a prior auth include notification of authorized service request(s) to enrollees and providers
- Electronic capture of provider clinical information to support UM decisions
- Links to useful tools, such as Milliman Care Guidelines (MCG) and Customer Care system, to enhance user efficiency
- Integration of our clinical platform for UM and Care Management – including physical health, behavioral health (BH), and social determinants of health (SDOH)

Appropriate Staffing Levels and Qualified Associates

Our Louisiana UM program will be overseen by our plan [redacted] licensure, and experience, including staff specifically assigned to SHS and PSH, per **Model Contract Section 2.12.5.5**. We will refer cases requiring clinical review to a Louisiana-based associate with the appropriate clinical licensure for a decision based on medical necessity. If the case cannot be approved based on medical necessity, it is forwarded to a Medical Director for review. **Only physicians with an active Louisiana license can make an adverse determination based on medical necessity**.

Ensuring Consistent Application of Review Criteria

Consistent decision-making is critical to uniformly apply medical necessity by physician and non-physician reviewers. We conduct ongoing training and auditing for UM staff to ensure correct selection and consistent application of review criteria:

- **Inter-Rater Reliability (IRR):** We perform IRR audits of physician and non-physician reviewers at least annually to measure their consistency in selection of guidelines and application of criteria-based decision-making. If reviewers score less than the desired threshold, they re-take the examination. If they score less than the threshold on their second try, they undergo additional training. **Our Florida market reviewers achieved a 97% passing rate in our annual 2020 IRR audit, revealing minimal variability in UM determinations**.
- **Monthly Case Review Audits**: Humana conducts monthly case reviews using NCQA-endorsed methods. We review each case for correct guideline chosen, appropriate determination, and timeliness of determination, including notification to the enrollee and/or provider as required. We discuss and review any failed element for opportunity for further training.
- [redacted]
- **UM Training**: Upon hire, all UM staff receive four weeks of robust training, followed by four to six weeks of preceptor training, where an experienced UM associate mentors the new associate and verifies their readiness. We notify associates and provide training when we revise policies and procedures and review them individually, as teams, and/or through in-service updates.

2.6.10.2 Satisfying Requirements for Utilization Management per Model Contract 2.12

Humana has established processes and procedures in place that meet the requirements in **Model Contract Section 2.12**. [redacted] eporting directly to the **Quality Assurance and Performance Improvement (QAPI) Committee**, the UM Committee will oversee all Humana and network providers UM activities.

2.6.10.2.1 Proposed Criteria of Utilization Management Process

Our UM guidelines adhere to all federal and State regulations, enrollee benefit coverage and contractual requirements. We will ensure that our guidelines are no more restrictive than the State Medicaid program, including quantitative and non-quantitative treatment limits. Humana maintains a corporate license to use **MCG**, externally developed, peer-reviewed, evidence-based, standardized criteria created to support effective UM, as well as **American Society for Addiction Medicine (ASAM) for substance use**

disorder (SUD). When necessary, we supplement MCG and ASAM with guidelines from nationally recognized organizations, including but not limited to:

- American Academy of Child and Adolescent Psychiatry
- American Diabetes Association
- American Heart Association
- American College of Chest Physicians
- Centers for Disease Control and Prevention
- American Academy of Pediatrics
- American Academy of Family Physicians
- American Congress of Obstetricians and Gynecologists
- Agency for Healthcare Research and Quality
- American Psychiatric Association
- National Quality Forum

Through routine interaction with our provider-facing staff and participation in our Provider Advisory Council (PAC), **we will elicit ongoing input from our Louisiana network providers to ensure our UM program evaluates local trends and continuously meets enrollee and provider needs**. We will share feedback with our UM Committee and incorporate into our guideline approval process. **We will also promote participation in our PAC from a variety of provider types, including BH providers and pharmacists, as well as at least one provider representative from each region of the State.**

In Q1 of 2020, our Kentucky Medicaid plan reviewed prior auth requirements for occupational, physical, and speech therapies due to provider feedback. Based on this feedback and industry standards, Humana removed the prior auth requirement for the first 20 visits and allowed providers to submit clinical documentation for enrollees to receive additional visits. This update allowed Humana to successfully alleviate provider administrative burden and enhanced our enrollees' ability to receive needed therapies in a timely manner.

Monitoring and Evaluation of UM Criteria

At least annually, we use systematic processes and robust data analytics to monitor our UM program and utilization trends via our **formal QI program evaluation**. The UM Committee reviews our program guidelines annually, or more frequently if needed. Guidelines are subsequently presented to our Continuous Quality Improvement Committee (CQIC) for approval. The CQIC meets on a quarterly basis and reviews, provides guidance, and makes recommendations regarding policies and procedures, UM criteria, quality standards, and related legal, regulatory, and accreditation requirements. After we update or approve a guideline or a new guideline, we post updates on our public-facing website. This centralized and integrated approach ensures timely sharing of best practices across markets. Through this process, we also evaluate our PAL against a set of internal and external metrics, including comparing our PAL versus our competitors. We adjust our PAL accordingly: **in 2019, we removed 24.5% of procedures from our PAL, ultimately reducing provider burden and promoting seamless delivery of care for our enrollees**.

Applying UM Criteria to Determine Appropriateness of Treatment and Site of Treatment

Humana's Clinical staff and Medical Directors use our established policy guidelines, which encompass all care acuity levels, to support medical necessity decisions. However, these guidelines do not replace clinical judgment. **We review service authorization requests based upon the State Coverage Manual, MCG, ASAM (where applicable), and our State-approved Humana Medical Coverage Policies**. EPSDT requirements are incorporated into all reviews for enrollees under the age of 21. **Humana incorporates BH into all aspects of our QI and UM programs**; our [redacted]

Humana reviews all inpatient stays against medical necessity criteria to determine appropriateness of treatment, and works with providers when those criteria are not met to ensure the enrollee is receiving the most appropriate care. We provide peer-to-peer consultations between the attending physician and a Humana Medical Director when the front-end review results in a denial of inpatient status. **As a result of implementing this enhanced front-end review, we achieved a 9.7% decrease in the observation rate and a 16.3% decrease in admissions per thousand to date in our Florida market in 2020.**

2.6.10.2.2 Monitoring and Addressing High Emergency Room Utilization

Our robust IT infrastructure and reporting capabilities support Humana's UM processes to ensure effective discharge planning and engage enrollees and providers in better managing care to reduce emergency room/emergency department (ER/ED) utilization. These strategies have proven successful: **since 2016, we have reduced nonemergent admissions by 47%, readmissions by 38.7%, and ER/ED visits by 8.3% per 1,000 for high utilizers in our Florida Medicaid market.**

Monitoring High ER/ED Utilization

We use an array of sophisticated analytical tools to proactively identify enrollees at risk of potentially preventable ER/ED utilization and to monitor trends. [redacted] With the EIR, users, including UM leaders, can view overall performance and drill down to specific data elements to analyze data quickly and identify root causes. The EIR also includes front-end review metrics to monitor appropriate inpatient versus observation utilization. Our Data and Analytics, UM, Quality, Pharmacy, BH, and CM teams review these reports monthly and collaborate on timely and appropriate interventions. The software consolidates these tools, in addition to supplemental enrollee demographic data, to create automatic and immediate CM referrals. We review these algorithms on an ongoing basis to ensure they are up to date on emerging trends in our populations.

Addressing High ER/ED Utilization

Promoting Appropriate Care Seeking Behaviors

> Humana is contracted with urgent care centers in all of Louisiana's nine regions. We educate enrollees on urgent care availability and appropriateness in the Enrollee Handbook and via tools such as the Nurse Advice Line and our Provider Finder tool, which utilizes geo-tagging to show enrollees the urgent care centers closest to their location.

Based on the **RFP Data Book**, regions with lower primary care utilization showed higher rates of inpatient utilization. Our approach to managing inappropriate ER/ED utilization for Louisiana will rely upon providing extensive services to support appropriate care and employing a multichannel approach to educating enrollees on appropriate care seeking behaviors and their available services. To expand enrollee access to care, Humana will offer the following programs:

- **Building Capacity:** Humana is partnering with **Ochsner to build primary care clinics in underserved areas** that will deliver high-quality care in the community setting, enhancing access and alleviating health disparities among vulnerable populations.
- [redacted]
- **Remote Patient Monitoring (RPM):** To support enrollee self-monitoring and enable providers to gather data outside of the healthcare setting, we will offer RPM for diabetes care, cardiology, maternal fetal medicine, and neurology. **In addition to glucose pumps and monitors, Humana will also provide blood pressure cuffs, scales, and home visits**.
- **Paramedicine for Episodic and Urgent Care:** In partnership with local emergency medical services entities/vendors, we will provide post-discharge care and/or community-based care for frequent ER/ED utilizers. We will connect a network of neighborhood-based responders, such as emergency medical technicians, nurses, and firefighters, supported via video with telehealth doctors, to patients

who need nonemergent care. These responders will perform medication reviews, follow-up with our enrollees' care teams, and share reports with the enrollee's PCP to support continuity of care.

- **Specialized Telephonic Health Coaching Programs:** Humana offers individualized health coaching for SUD, PTSD, Adverse Childhood Experiences (ACEs), diabetes, tobacco cessation, and weight management.
- **Member Incentives:** We incentivize enrollees to access timely care in appropriate settings, [redacted].
- **24/7 Access to Clinical Support:** Enrollees may contact our **Medical Advice Line and BH Services Crisis Hotline**, which guide enrollees to the appropriate level of care in an immediate crisis, 24/7. Enrollees who have contacted these lines receive a follow-up call on the next business day to offer assistance and evaluate ongoing needs, including the potential to benefit from Care Management and/or SDOH support. **Our pregnancy mobile application also includes direct access to a 24/7 nurse line**.
- **Comprehensive Value-Added Benefits (VAB):** We offer a range of VAB tailored to the needs of each of our populations. [redacted] staff, network providers, and community partners can access our robust community resources directory with **closed-loop referral** capabilities, enabling a coordinated and timely approach to addressing the social drivers that impact our enrollees' health. Humana's national Bold Goal initiative focuses on addressing the SDOH that drive healthy behaviors which has **achieved year-over-year reductions in unhealthy days for four consecutive years in Baton Rouge**.

We educate enrollees on the above services, appropriate care seeking behaviors, and on the importance of preventive care and condition self-management using in-person, text, and telephonic engagement and outreach; written communications through mail and email newsletters, our website, and the enrollee portal; and seasonal campaigns. Across our Medicaid markets, we recently launched a multichannel ER/ED diversion campaign, **Where to Go for Care**, to education high utilizers on appropriate care seeking behaviors and relevant Humana programs. **We send out multichannel communications to targeted enrollees in both English and Spanish**.

Prompt Referrals to and Promotion of Engagement in Care Management

We use our ER/ED predictive model, as well as historic ER/ED visits, as inputs into CM risk stratification model. Our proprietary **ER/ED Predictive Model** quantifies the likelihood of future ER/ED utilization for each enrollee, using cost and utilization for different clinical, behavioral, and functional conditions as well as socioeconomic profiles. Enrollees with a history of frequent ER/ED utilization receive multiple outreach attempts from our Care Management team for assessment of unmet needs, including physical health, BH, and SDOH, and for inclusion in Care Management. Our Case Managers educate their assigned enrollees on appropriate care-seeking behaviors, including recognizing when they should go to the ER/ED, which conditions can be treated in an urgent care center, when a call to their PCP, or when our Medical Advice Line may be more appropriate.

Engaging Providers to Address High ER/ED Utilization

We view our network providers as key partners in improving enrollee health outcomes and managing ER utilization. We employ a multifaceted approach to encouraging appropriate and timely management of enrollee needs, including:

- **Supplying Providers with Timely and Actionable Data**: Through direct connection with electronic health records (EHRs), our Medical Record Management application enables seamless sharing of medical record information between providers and our Care Management teams, including the transmission of admit, discharge, transfer (ADT) data in near real-time. We regularly share provider reports through our Provider Portal and through in person engagement with **Provider Performance Improvement Advisors** (PPIAs) who conduct targeted education for providers with high utilization metrics. Further, our provider **Population Insight Compass Tool** provides an integrated view of gaps in care, services, and needs, including enrollee ER/ED use, across the provider's patient panel and turns these data into actionable reports. **Provider profiling** offers provider-level reports of claims and encounter data to analyze over-utilization and provide peer-to-peer analysis, allowing us to pinpoint trends. This actionable data enables providers to conduct timely outreach, informs their care processes, and drives our approach to provider education.
- **Enhancing Provider Capabilities and Infrastructure Through Practice Transformation**: Through our practice transformation model, dedicated and experienced **Practice Transformation Specialists** work directly with providers to identify areas where the practice could improve care delivery, technological infrastructure, or care coordination, and tailor our supports to their individual needs.
- [redacted]

Promoting the Delivery of Integrated Care: In our Florida Medicaid plan, Humana facilitated a partnership between Pediatric Associates (a provider group operating under a risk-based, total-cost-of-care contract) and Chrysalis Health (a BH care services provider) to co-locate BH professionals into three high-volume practices. We incentivized the adoption of advanced care models by aligning reimbursement rates to support and sustain co-located services to enhance timely access to BH services; improve PCPs' ability to address BH needs; reduce gaps in care; increase BH referrals; and mobilize community support resources. **Between 2018 and 2019, we found the participating practices improved BH referral adherence by 26% and reduced ER/ED utilization by 8%**. We have similarly supported the advancement of integrated care delivery in Louisiana. Through our partnership with the Capital Area Human Services, Humana's Bold Goal directly supported the integration of BH services within a multispecialty clinic in Baton Rouge. Most referrals result in an appointment within one week, although same-day access is possible. Based on a pre-/post-analysis for Medicare enrollees with claims both 12 months before and after referral to the integrated clinic, **we found that participation in the pilot reduced inpatient utilization by 60%, ER/ED utilization by 25%, and outpatient utilization by 17%. Leveraging this experience, we will prioritize fostering dynamic provider relationships and incentive arrangements to enhance integrated care delivery for Louisiana Medicaid.**

2.6.10.2.3 Process for Pre-Admission Screening and Resident Review (PASRR) and Concurrent Reviews

Humana's PASRR Processes

Our PASRR policies will fully comply with **Model Contract Section 2.7.7 and all requirements in the MCO Manual.** We will ensure enrollees are not inappropriately placed in nursing homes for long-term care. Within our integrated clinical platform, Humana will ensure PASRR Level I evaluations are completed and all enrollees are evaluated for mental illness and/or intellectual disability for appropriate treatment in the appropriate setting. **We will employ trained licensed mental health professionals (LMHPs) in all regions of the State** to complete the PASRR Level II in person for all enrollees within four calendar days of notification of a positive PASRR Level I (excluding those enrollees with a developmental disability) or referral from LDH. Upon completion, Level II evaluations are stored in our clinical platform and will be submitted to the Office of Behavioral Health (OBH). If OBH determines nursing facility services are not appropriate, Humana will assist eligible enrollees to obtain alternative BH services available under this Contract.

Humana's Concurrent Review Processes

Humana always considers requests for ongoing inpatient care as urgent. As such, we have nurses and physicians on call to conduct concurrent reviews for ongoing services. Our concurrent review includes:

- Clinical utilization review to ensure coordination of inpatient services as ordered and specialist provider referrals within the network to prevent duplication of outpatient services
- Coordination of discharge services including utilization review for appropriate discharge to skilled, long-term acute care, and acute rehab levels of care
- Referral for CM, BH, and SDOH services based on enrollees identified needs.
- Communication and provision of updates to Interdisciplinary team (ICT) for transitions of care
- Coordination with the hospital team and outpatient providers on enrollees' Plan of Care

As part of our ongoing concurrent reviews, we hold twice-weekly **integrated UM rounds** during which Humana's Medical Directors, UM nurses, and Case Managers review cases of enrollees currently admitted to a facility, evaluating both physical health and BH cases. Humana Medical Directors conduct specialized rounds on complex cases, including adults hospitalized for more than 14 days and adolescents and pregnant enrollees hospitalized for more than seven days, and meet with UM nurses on a monthly basis to discuss medically complex children.

Our Concurrent Review associates also play an important role in discharge planning with facility staff to ensure timely discharge, with a safe discharge plan in place, including a BH crisis plan, as applicable. This includes a psychosocial assessment to identify gaps in care, educational needs related to disease processes, medication adherence, SDOH needs, and communication of enrollee's needs to PCPs to better assist with discharge decisions and coordination of care. **Upon discharge, all enrollees receive outreach from Humana's Clinical teams**. For enrollees actively engaged in Care Management, the enrollee will receive a call from their Case Manager upon discharge and enrollees not actively engaged in Care Management receive outreach for screening and referral to Humana clinical programs, as appropriate.

> "My office is very pleased to have the Humana Nurse Liaison on our team. Being she is onsite at the hospital, we can trust without a doubt that our enrollees are taken care of and are receiving the quality of care they deserve."
> - Royal Palm Medical Center, Royal Palm Beach FL

We will place UM nurses onsite in high-volume facilities (with facility permission) to coordinate with our on the ground care team and conduct face-to-face discharge planning. **Our On-site Nurse Liaison program** facilitates a personalized enrollee experience to holistically assess individual enrollee needs. Onsite nurse liaisons work with our UM Transition Coordinators, our BH UM staff, and Community Health Workers (CHWs), to facilitate a smooth discharge and transition back into the community and will conduct individualized enrollee assessments to identify gaps in care and SDOH needs; direct real-time enrollee intervention and

coordination of services that facilitate a successful transition of care from the inpatient setting; convene with the enrollee's PCP, hospitalist, Humana Care Management team, and hospital team to ensure a collaborative approach; and improve provider relationships and engagement among ICTs.

Humana's Discharge Planning Processes Ensure Follow-Up Attendance and Reduce Readmissions: At the beginning of 2020, our Illinois Dual Demonstration program implemented an initiative to increase post-hospital discharge follow-up appointments. Under this initiative, the assigned Humana UM nurse asked the facility to schedule a post-discharge follow-up appointment while the enrollee was still hospitalized. Further, the Care Management team included two additional questions in their enrollee post-discharge follow-up calls to ensure the enrollee had a post-hospital follow-up appointment scheduled, including transportation to the appointment, and scheduled appointment and transportation services as needed. **As of the end of November 2020, 97% of our enrollees completed a follow-up appointment 30 days post hospital discharge.**

2.6.10.2.4 Complying with Mental Health Parity Requirements

Humana is committed to ensuring the MHPAEA requirements are embedded throughout our Medicaid operations. Our analysis ensures benefit limitations on medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) benefits are not more restrictive than benefit limitations on M/S benefits in the same classification and will comply with **LDH's MHPAEA Compliance Plan**. The analysis includes QTL and NQTL. We will prepare this analysis using the guidance provided in the **CMS Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements** (Toolkit). Humana will use the step-by-step process in the Toolkit to perform the QTL analysis and the NQTL grid to complete a review and analysis of NQTL compliance.

> In November 2019, our Florida Medicaid market completed their annual MHPAEA review and identified an opportunity to better align our expanded benefits across MH/SUD and M/S. As a result of the review, Humana removed the benefit limitations and authorization requirements for equine therapy and home visits by a social worker in February 2020.

When Humana implements a new Medicaid contract**, our Mental Health Parity Governance Lead, Tricia Cloud, works with the Market leadership, Implementation lead, Product Development, Provider Network, UM, Pharmacy Director, Population Health Management and Healthcare Services leaders to complete the MHPAEA analysis.** We will compare the formulas and grids from the Toolkit to the Louisiana Medicaid Program to measure and track compliance for QTL and NQTL, with a particular focus on the actuarial formulas for the QTL analysis and the comparative analysis grid for the NQTL using the Questionnaire- Example B provided in the Toolkit. Humana's processes, strategies, evidentiary standards, and other factors used to apply NQTLs to MH/SUD are comparable to, and applied no more stringently than, those used to apply the limitation with respect to M/S benefits in in accordance with the MHPAEA. Humana has instituted processes, controls, and governance to set and ensure compliance with NQTLs when we are implementing a new Medicaid contract. Ongoing oversight ensures continued compliance. We conduct an updated MHPAEA analysis in the following situations:

- The benefit design or benefit operations change
- A State Contract Amendment change affects the benefits, QTLs, or NQTLs
- Any changes made to the PAL
- Annually if none of the above reasons require an updated analysis to be completed

2.6.10.2.5 Identifying and Mitigating Over-Utilization

Identifying Over Utilization

Humana employs systematic processes to continuously monitor utilization and costs to appropriately stratify enrollees for intervention. Our Data and Analytics teams identify high utilizers using industry-leading tools, described in **Table 2.6.10.2.**, using factors such as enrollment information; enrollee demographics; medical, pharmacy, and lab claims; authorizations; clinical conditions; and SDOH data.

Table 2.6.10.2: Humana's Dashboards and Reports to Monitor Utilization

Report	Description
Inpatient Census Report	Daily detailed account of acute and sub-acute inpatient facility admission cases
Potentially Preventable Events (PPE) Report	Identifies admissions, readmissions, facility-based complications, ER/ED visits, and ancillary services that likely could have been prevented
Inpatient Clinical Dashboard	Weekly reporting of key operational metrics, such as time from receipt of authorization to nurse receipt, time for clinical decisions, discharge plan documentation, enrollees contacted for post-discharge follow up, clinical program reach and engagement rate.
Early Indicator Report	Monthly reporting of key utilization metrics, such as admits/1,000 by utilization type, inpatient days/1,000, length of service by type, ER/ED visits/1,000, etc. Dashboard format allows user to drill-down for analysis by demographics, such as geographic region, plan type, and age of user.
High Utilizer Report	Monthly report allowing us to drill down into individual enrollees with high utilization by service type, e.g., ER/ED, inpatient care, etc. as well as provider denials
Provider Profiling	Quarterly provider-level report of claims and encounter data to analyze under- and over-utilization and to provide peer-to-peer analysis
Predictive Model Reporting	Predictive Model for Severity Score, updated monthly, and Inpatient and Readmission Model, updated daily from admission to discharge are integrated into our **Integration Plus Population Health (Integration+)** platform to trigger referrals for clinical programs; ER/ED Predictive Model scores available by report each month and are integrated into the Platform; Opioid Predictive Model to identify high-risk enrollees
Readmissions by Provider Report	Monthly tracking of 14- and 30-day readmission rate for acute admissions and physician visit within 14 days of discharge date
Provider Payment Integrity Report	Monthly tracking and dashboard related to provider payment outlier analysis and trending and analysis to identify potential fraud, waste, and abuse
High Cost Prescription Report	Report identifying enrollees who have 10 or more unique drugs that average more than $250 per prescription
Pharmacy All Claims Detail	Report providing enrollee, prescriber, and pharmacy claims detail for all pharmacy claims processed within the selected time period

On a monthly basis, our Data and Analytics, UM, Quality, Care Management, Pharmacy, and BH teams review the above reports and collaborate on timely and appropriate interventions. In addition to this monthly reporting, our software takes all of the previously mentioned tools, in addition to supplemental enrollee demographic data, into account to create Care Management referrals. We review these algorithms on an ongoing basis to ensure they are up to date on emerging trends in our populations.

Mitigating Over-Utilization

Once we have identified over-utilization either at the individual enrollee level, or as a population-level trend in certain regions, we seek to identify the drivers of the increased utilization and develop strategies to address root causes.

Timely Enrollee Intervention: When we identify an enrollee who is at risk for or has had high utilization through the above-described processes, our Care Management teams conduct outreach to engage the enrollee in our Care Management programs. In addition to multiple phone and mail outreach attempts, we rely on the broad reach of our field-based staff to locate and engage with enrollees in their communities. We will leverage our Louisiana-based CM team to locate hard-to-contact and high-risk enrollees and engage or re-engage them in care.

Engaging or Re-Engaging Enrollees in Care Management: Our Care Management approach prioritizes enrollee education on available programs, enhances care coordination with the enrollee's ICT, supports chronic condition management, identifies and addresses social needs, and promotes appointment attendance and routine preventive care.

After identifying a growing number of high-cost and/or potentially preventable events for COPD, asthma, heart failure, and diabetes among our Florida Medical enrollees, we developed a standard of care for our Care Management program to improve clinical outcomes, reduce preventable admissions/readmissions, and ER/ED visits. Specifically, we developed a set of critical data elements to be collected at each condition-specific encounter based on widely accepted, evidenced-based guidelines. These elements help identify gaps in care and our Humana Care Management team partnered with PCPs and specialists across the state for improved delivery of care based on gaps. To date, this initiative has achieved significant results for all targeted populations:

COPD:	30% reduction in IP admissions post engagement with Care Management; 90% of engaged enrollees had their annual PCP visit.
Asthma:	28% reduction in ED visits post engagement with Care Management; 95% of engaged enrollees had their annual PCP visit.
Heart Failure:	44% reduction in IP admissions post engagement with Care Management; 93% of engaged enrollees had their annual PCP visit.
Diabetes:	37% reduction in ED visits post engagement with Care Management; 96% of engaged enrollees had their annual PCP visit.

Ensuring Appropriate Pharmacy Utilization: We actively monitor, track, and report on pharmacy utilization and indicators to identify potential areas of overutilization. We deliver reports to our network providers indicating potential areas of concern, including reports on:

- **Enrollees with Unique Drugs:** A configurable report that flags enrollees with unique prescriptions over a determined threshold and details the number of prescribers, total prescriptions, and total prescription cost. We establish this threshold for each market based on utilization patterns.
- **All Target Claims Detail:** Humana has identified lower cost formulary alternatives for a select number of medications. The report identifies members who have been prescribed one of the selected medications and provides one to two lower cost alternatives with associated savings if the prescriber changes the therapy.
- **All Claims Detail:** Report provides enrollee, prescriber and pharmacy claims detail for all pharmacy claims processed within the selected time period.

We monitor inappropriate prescribing and utilization to ensure appropriate drug product use. Through pharmacy claims review, we identified overutilization with a major provider group in our Florida Medicaid program, dispensing attention deficit hyperactivity disorder (ADHD) medications just over 2.8 times higher than the state average in Q3 2019. **We deployed targeted outreach and education, including sharing actionable data with the group, ultimately resulting in a reduction of their spend in the drug class by more than 11%.**

Humana has experience successfully working with Louisiana providers to improve outcomes and reduce costs. Humana's Louisiana-based Medicare Advantage value-based arrangements achieved a **21.5% cost savings** (compared to Medicare FFS) in 2019, driven by a **27.5% reduction in inpatient admissions** and **2.5% reduction in ER/ED visits**.

Provider Engagement Approach: We work directly with our providers to continuously track, monitor, and analyze utilization patterns. We supply providers with timely and actionable data to support provider intervention for our enrollees through our provider portal, Availity, and through interactions with our PPIAs. Provider profiling offers further provider-level report of claims and encounter data to analyze under- and over-utilization and to provide peer-to-peer analysis. We also engage various Provider types to enhance enrollee access to care, including offering an **Extended Hours Bonus** for PCPs and BH Providers and leveraging shared risk arrangements to encourage providers to address high utilization.

Ongoing Monitoring and Evaluation: On a monthly and ongoing basis, our Data and Analytics, UM, Quality, pharmacy, BH, and Care Management teams review the previously described reports, enrollee interventions, and provider performance. Through this close collaboration, we ensure a comprehensive approach to designing and implementing interventions. All interventions are continually monitored for effectiveness, enabling us to continuously refine our approach to meet enrollee needs. Quarterly, we formally report trends and initiatives to our market-based QAPI Committee.

2.6.10.3 Experience with Utilization Management of Comparable Populations

Through our experience operating dynamic UM programs, we have broad experience analyzing trends, pinpointing root causes, and implementing tailored interventions and process improvements that measurably reduce costs and address inappropriate utilization. **Our strategies are effective: in our Florida Medicaid program we achieved a 38% reduction in ER visits, an 18% reduction in inpatient admissions, and 19% reduction in acute readmissions per 1,000 between 2018 and 2020.**

2.6.10.3.1 Challenges Identified with High Utilization and Increasing Medical Trends

Our experience managing the physical, behavioral, social, and pharmaceutical needs of diverse enrollees has taught us that effectively managing high utilization and increasing medical trends requires a proactive and whole-person centered approach. Challenges and lessons learned **in Table 2.6.10.3-1** include:

Table 2.6.10.3-1: Challenges Identified with High Utilization and Increasing Medical Trends

Challenge	Description
Inappropriate Use of the ER/ED	Various factors have contributed to our Medicaid enrollees inappropriate ER/ED. We found the lack of after-hours access to primary care, lack of awareness of other level of care options, and various SDOH (food insecurity and homelessness) are major drivers of overutilization of ER/ED services. Increasing access to rural and underserved areas also presents a challenge in our Florida program. When our enrollees cannot reliably access necessary primary care, they turn to more costly, less effective care options. We also see the impact of lack of access in overall medical trends. Where there is underutilization of primary care services, there is an increase in high cost, low-value care, sometimes culminating in an inpatient stay due to the exacerbation of existing conditions.
Enrollee Barriers to Follow-Up Appointment Attendance	Ensuring enrollees keep their follow up appointments and are referred to appropriate services is critical to reducing readmission rates. Across our Medicaid plans, we have found that engaging enrollees and their care teams while inpatient and immediately upon discharge helps us to effectively engage the enrollee and understand the barriers to care they may face. Often, enrollees express SDOH needs, including transportation, which hinder their ability to seek routine care.
Identifying Disease and Demographic Drivers of Utilization Rates	When we identify an increase in utilization rates, we have often found that specific disease conditions or demographic factors are often the main drivers. In our Florida Medicaid program, upon identification of increasing potentially preventable readmissions in 2017, we conducted a thorough claims and encounter data analysis to examine conditions contributing to the highest number of readmissions. We found that sickle cell disease, a disease that disproportionately affects Blacks, was one of the top contributing conditions for preventable readmissions, accounting for 15% of total readmissions.

2.6.10.3.2 Initiatives Undertaken to Manage High Utilization

When we identify barriers, our cross-departmental teams implement initiatives to address root causes that measurably reduce costs and decrease inappropriate utilization. We use lessons learned to prioritize and operationalize strategies for improvement shown in **Table 2.6.10.3-2**.

Table 2.6.10.3-2: Initiatives Undertaken to Manage High Utilization

Challenge	Initiative Undertaken
Inappropriate Use of the ER/ED	Every month, Humana's Florida Medicaid Health Services teams meet to review the EIR and discuss emerging trends, year-over-year metric comparisons, additional reporting needs, and initiatives/pilots designed to improve metrics. Through this forum, our clinical and network teams noticed areas of our network that had limited urgent care access, which contributed to a 6.3% increase in potentially preventable ER/ED visits from 2016 to 2017. Humana subsequently launched an **urgent care strategy** that included contracting with additional urgent care centers to expand access. **We saw an immediate 2.6% shift from the ER/ED to urgent care from 2017 to 2018**. Humana is continuing this strategy by launching enrollee and provider education campaigns and implementing a provider **after-hours incentive**.

Challenge	Initiative Undertaken
Enrollee Barriers to Follow-Up Appointment Attendance	We employ tailored and proactive discharge planning processes across our Medicaid markets to promote follow-up appointment attendance to reduce readmissions. In our Illinois Duals program, we recently added two questions to our post discharge survey to ensure the enrollee has a follow-up appointment scheduled and transportation to that appointment. We achieved an over **11-point increase in our rate for Follow-Up after Hospitalization for Mental Illness within 30 days based** on YTD 2020 data. In our Florida program, we are currently monitoring a PIP to enhance our BH discharge planning process to: 1) Ensure structured assessment of enrollee discharge needs and plan is communicated with inpatient provider within two days of admission; 2) Confirm if enrollee is linked to a BH provider; 3) Conduct CM outreach and engagement within three days of discharge. We have already observed increase compliance with follow-up PCP appointment attendance among enrollees targeted through this enhanced process.
Identifying Disease and Demographic Drivers of Utilization Rates	To address the driver of readmissions and health disparity in our Florida plan, we partnered with Johns Hopkins University to create a **Sickle Cell Center of Excellence** and develop clinical best practices and disease-specific education on sickle cell disease. Program components include targeted questions added to the HNA to identify new enrollees with sickle cell disease, specialized outreach to enrollees with sickle cell, creation of enrollee- and provider-focused education, and provider training on environmental influences on child health outcomes. **Enrollees engaged in this program exhibited a 35% decrease in average length of stay for inpatient admissions, a 51.3% in PMPM costs, and overall ER/ED visits decreased by 11.2% from 2017 to 2019.**

2.6.10.3.3 Initiatives to Address Use of Low Value Care

Our UM systems and processes detect and address underutilization of high-value services and overutilization of low-value services. We deploy targeted enrollee and provider education and engagement strategies to reduce utilization of low-value care. **Upon award, Humana will collaborate with network providers to identify areas of opportunity and launch a targeted intervention to address low value care in alignment with LDH's Quality Strategy.**

Provider Engagement Strategies

Humana's Louisiana-based PPIAs will work directly with providers to review utilization patterns and identify areas for improvement, such as closing gaps in preventive care, in order to promote appropriate utilization and improved health outcomes. We supply providers with actionable reports, tools, and supports to identify low value care and implement improvements:

- **Care Decisions Insights (CDI)**: Humana's CDI tool allows us to share information with our providers to improve their patients' care by using specialists that demonstrate high efficiencies and effectiveness. CDI encourages provider groups to consider and incorporate cost and quality insights into their referral decisions. For PCP groups, CDI data may provide reassurance that the specialist whom they refer their patient to is not only in network, but also is recognized for delivering quality, high-value care and improved patient outcomes. Through this innovative platform, we give PCPs information about the most efficient and effective specialists in Humana's network. For specialists, the CDI program gives details regarding how their performance compares to their peers. We include CDI results in the provider directory, which allows PCPs and enrollees to choose their preferred providers based on their quality score, driving enrollees to providers who have a proven track record of delivering high-value care.
- [redacted]

Promoting High-Value Care Through Targeted Enrollee Engagement and Education

Humana's UM processes also identify areas where enrollees may be underutilizing key preventive or supporting services, leading to an increase in low-value care. We use our UM systems and process to identify enrollees who may not be receiving the appropriate amount of services for their identified condition or situation. In our Florida program, we recently identified that 63% of our enrollees attributed to one of our large provider groups had not been seen by their PCP in the last 12 months; of those, 9% had two or more ER/ED visits and 31% had two or more active care gaps. We subsequently deployed comprehensive enrollee outreach and education to reconnect these enrollees with their PCP. A Humana Case Manager conducted outreach to all identified enrollees to complete the HNA, schedule a PCP appointment, educate and refer the enrollee to Humana clinical programs, including SDOH programs, and provide education on appropriate care seeking behaviors. In advance of the enrollee's appointment, the Case Manager conducted another round of outreach to ensure the enrollee's attendance and sent a gap list to the provider office as well as confirmed the enrollee's medication list. **Of those reached, we have successfully engaged 76% of our targeted enrollees and achieved the following results: 23.3% of enrollees reached attended a PCP appointment; 88.3% received education on appropriate levels of care; and 42% were connected to SDOH resources.**

> Upon contact with one of our Florida Case Managers through this program, an enrollee expressed gratefulness in reconnecting with Humana as she had recently moved from Jacksonville to Palm Coast. The Case Manager assisted the enrollee in updating her contact information, connected the enrollee to new community resources in her neighborhood, scheduled a PCP appointment, referred her to BH services for continuation of treatment, and provided education on the importance of dental health.

2.6.10.3.4 Addressing Long-Term Stays in the ER/ED Based on Limited Availability of Mental Health and/or Substance Use Services

Our approach to decreasing the number of enrollees seeking care for mental health and substance use disorder (MH/SUD) services in the ER/ED prioritizes quickly identifying enrollees who present at the ER/ED and transferring them to the appropriate care setting.

> Humana is partnering with Oceans Healthcare to pilot an innovative VBP model that will improve quality of care and reduce costs for enrollees transitioning between inpatient and outpatient BH services.

Prompt Identification: This process begins with ensuring we receive timely notification of enrollees presenting at the ER/ED with BH needs. Through experience in our Kentucky plan, we have learned the critical importance of reaching enrollees presenting at the ER/ED with an opioid overdose within 48 hours of discharge. Our Care Management teams conduct outreach to coordinate care needs and connect the enrollee to a MAT provider or residential treatment center. **Our connection to Louisiana HIEs enables us to receive timely and actionable ADT data. Upon notification of admission, we will conduct outreach to all enrollees admitted to the ER/ED with BH needs within two calendar days**. **Humana's Practice Transformation Incentive provides financial supports to help providers establish HIE connection, promoting increased statewide ADT data.** Where there are hospitals not connected to an HIE, we will employ targeted engagement strategies to educate providers on the critical importance of timely notification of enrollees presenting at the ER/ED with BH needs. Humana will dedicate a **specialized BH UM Liaison** to act as our hospital point of contact to maintain ongoing communication with local hospitals, provide education and assistance, and ensure all identified enrollees presenting at the ER/ED for BH needs receive timely and appropriate care.

Locating the Most Appropriate Care Setting: Upon enrollee admission to the ER/ED, a BH UM associate works directly with the hospital, ER/ED to find availability in an appropriate setting as soon as possible. If the ER/ED is able to find an available MH/SUD bed, our CIT begins the authorization process and our BH UM team assists the ER/ED in finding a facility the bed availability. This process initiates a request via our clinical platform for the BH UM team to secure a bed at an in-network facility. If we are unable to

find an in-network facility, the BH UM associate works with the enrollee, hospital, and receiving facility to arrange care at the closest out-of-network facility, understanding that we will continue approving the higher level of care until the enrollee can transition to the appropriate level of care.

Keeping Enrollees with BH Needs out of the ER/ED: We have found the most effective way reduce ER/ED stays for MH/SUD services is to divert those enrollees away from the ER/ED with more effective outpatient services or community resources. **Humana has shaped our community partnerships and strategic investments in Louisiana to expand access to MH/ SUD services**, as shown in **Table 2.6.10.3-3**.

Table 2.6.10.3-3: Humana's Partnerships to Expand Access to MH/SUD Services

2.6.10.3.5 Initiatives Undertaken to Support Providers with High Prior Authorization Denial Rates

We employ a multifaceted approach to identify and address trends in high denial rates. Our internal UM reporting dashboards provide prompt identification of providers and services encountering high denial rates. Humana's **UM and Provider Relations teams take a collaborative approach** to identify the root cause of the denials, with the UM staff examining our internal processes, and Provider Relations examining trends among the provider group. We examine our internal processes first to reduce any potential provider administrative burden. For example, in our Florida market, we identified an increased number of cases where denials were subsequently overturned on appeal for MRIs and CTs. We provided a report to the local QAPI Committee, which reviewed the metrics. Following this review, our Clinical Governance team made a determination, informed by CPGs, to remove both tests from the PAL, avoiding provider abrasion and ensuring seamless enrollee quality of care. When we identify the need for provider intervention, our Provider Relations staff works closely with our UM team to understand the reason for the denials in order to provide specific **in-person educational support**, be able to answer questions, and tailor the engagement to the particular provider's needs.

Kingsley House Senior program allows seniors to engage in gardening activities. Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

Section 2.6.11

Quality

Humana

Healthy Horizons™
in Louisiana

2.6.11 2.6.11 Quality

Humana Healthy Horizons in Louisiana has reviewed and confirms adherence to requirements in **Model Contract Section 2.16**.

2.6.11.1 Humana's Organizational Commitment to Quality Improvement

Guiding our day-to-day behaviors, decisions, and actions, quality improvement (QI) is foundational to Humana's enterprise mission and a core component of our business operations. With more than 1,000 associates fully dedicated to quality across the organization, we embed quality into everything we do. Our Louisiana market and national leadership actively engage in quality management/quality improvement (QM/QI) activities, and our QM/QI structure integrates all functional areas impacting quality of care. This approach ensures our integrated functional areas align their activities to identify areas of opportunity; implement, evaluate, and adjust evidence-based interventions; follow continuous quality improvement (CQI) methodologies; and remain responsive to current, emerging, and evolving enrollee needs.

> "Focusing on quality means taking an enterprise-wide view of whatever we do, going beyond our own areas of expertise to understand the effect of our decision-making on our organization and those we serve."
> – Bruce Broussard, Humana President & Chief Executive Officer (CEO)

Leveraging best practices, our deep understanding of Louisiana gained from serving Louisiana Medicare Advantage (MA) and Dual Eligible Special Needs Plans (D-SNP) enrollees for 36 years, and our experience driving improvement across Medicaid, our Louisiana Medicaid Quality Assessment and Performance Improvement (QAPI) program maximizes our proven commitment and approach to quality. **Humana Healthy Horizons in Louisiana is supported by more than 800 full-time equivalent (FTE) associates to support our QAPI program and QI activities to improve the health and well-being of our Louisiana Medicaid enrollees**. Our performance in National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS) ratings, where **Humana leads all national MA plans with 92% of our MA and more than 99% of Group MA beneficiaries enrolled in 4.0-Star plans or higher** in 2021, demonstrates our enterprise-wide commitment to quality and our capabilities as a quality leader:

- **Leading Quality in Medicaid:** All of Humana's Medicaid plans are NCQA-accredited or on a path to NCQA accreditation. Our NCQA-accredited Florida Medicaid plan is tied for **first in quality** among 10 participating Medicaid plans and has been among the top two plans for the past six years.
- **Leading Quality in Louisiana:** Humana operates two NCQA-accredited plans in Louisiana. **More than 178,000 of our Louisiana MA and D-SNP enrollees are in 4.5-Star plans**.
- **Track Record of Quality Success:** Humana operates **42 NCQA-accredited health plans** across our Medicaid, commercial, and MA lines of business. For three consecutive years our Florida MA plan achieved **a 5.0-Star rating** (a perfect rating).
- **Driving Continuous Improvement:** Since 2018, we have **driven improvement across 37 HEDIS® measures** aligned with Louisiana Medicaid's Quality Strategy, such as HbA1c poor control, follow-up after hospitalization for mental illness, and cervical cancer screening, in our largest Medicaid program, where we serve more than 620,000 Florida enrollees.
- **Advancing Culturally Appropriate Care and Health Equity:** We will pursue the **NCQA Health Equity Accreditation Plus** (transitioning from the Distinction in Multicultural Health Care, effective July 2022). Further, we offer our providers **Trauma-Informed Care training**, and the [redacted]

Approach and Strategies to Advance Quality Strategy and Incentive-Based Quality Measures

Humana's overall approach and our specific Louisiana strategies will drive improvement in Louisiana Department of Health's (LDH) priority areas. To achieve this, we assess our enrollees to identify needs; devise evidence-based strategies to improve health and well-being; and implement interventions addressing priority areas, the needs of enrollees with emerging risks, health disparities, and behavioral

health (BH) and social determinants of health (SDOH) needs. Our CQI methodology integrates enrollee and provider feedback, measures data, tracks trends, and monitors outcomes to adjust our approach. This comprehensive and collaborative approach enables our [redacted] MPP, to achieve the Triple Aim – better care, healthier people and communities, and smarter spending.

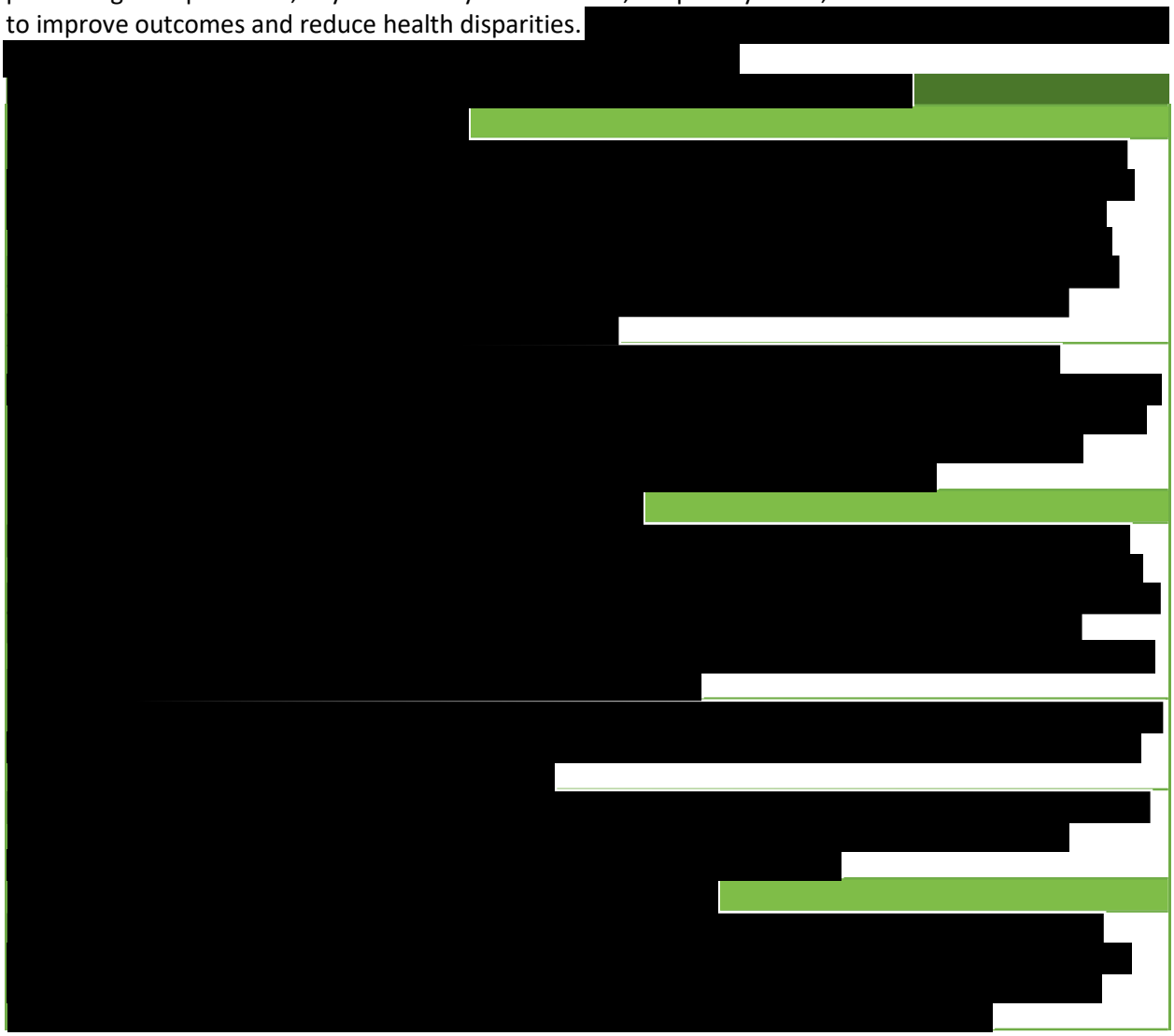
Integrated and Holistic Care Delivery Leads to Better Care

Humana coordinates and supports our enrollees' whole person health via our fully integrated, co-located care delivery model. To drive better care, we will implement **our evidence-based Louisiana Medicaid quality strategies** with examples outlined in **Table 2.6.11.1-1**.

[redacted]

Data-Driven Insights and Health Equity Focus Lead to Healthier People, Healthier Communities

Based on our national population health strategy known as our Bold Goal, our **Louisiana Medicaid Population Health Approach** will advance LDH's Quality Strategy, as described in **Table 2.6.11.1-2**. We are partnering with providers, key community stakeholders, hospital systems, and CBOs to co-create solutions to improve outcomes and reduce health disparities.



Pioneering Value-Based Care Leads to Smarter Spending

With more than 30 years of experience, Humana is a leader in establishing value-based payment (VBP) programs. Aligned with the incentive-based measures listed in **Attachment H, our Louisiana Medicaid Valued Care Plus (Valued Care+) VBP models** span diverse provider types, such as PCPs, OB/GYNs, BH providers, and specialists to deliver quality and value across the care continuum. All providers engaged in value-based arrangements have access to actionable VBP tools and Provider Relations associates to support care transformation. **We have an existing high-quality local network with 76% of our Louisiana MA enrollees attributed to value-based PCPs**. We also support the adoption and effective use of health information technology (HIT), such as health information exchange (HIE) connectivity and electronic health records (EHRs), to foster real-time data exchanges with our providers and enhance clinical decision-making that leads to smarter spending, shown in **Table 2.6.11.1-3**.

Quality Excellence

In 2020, our Florida Medicaid VBP program led to the following improvements: a **17.1% increase** in enrollees receiving follow-up care seven days after hospitalization for mental illness, a **15% increase** in enrollees screened for cervical cancer, and an **18.8% increase** in enrollees with diabetes receiving eye exams.

2.6.11.2 Humana's Approach to Improving Quality

Guided by CQI, our Quality and Analytics teams conduct in-depth provider performance and enrollee utilization analyses to identify under- and over-utilization and potential low-value care. Our teams monitor, analyze, and trend claims, labs, authorization, State-specified, and trending data from all stewards listed in LDH's Quality Strategy, including HEDIS. These insights yield an incisive understanding of utilization rates and prompt timely, tailored interventions and QI activities that measurably reduce costs and address the root causes of inappropriate utilization. Our strategies are effective: in our Florida Medicaid program **we reduced ED visits by 38%, inpatient admissions by 18%, and acute readmissions per 1,000 by 19% between 2018 and 2020**. We will incorporate the Louisiana State Health Assessment Dashboard into our analyses, ensuring our initiatives address key issues and barriers faced by distinct communities.

2.6.11.2.1 Assessment of Utilization Rates and the Potential for Improvement

Using our in-house analytics capabilities, **Table 2.6.11.2-1** explains our Medicaid Trend Analytics team assessed available Louisiana quality data and the data books that accompanied this RFP to reveal the following opportunity areas:

2.6.11.2.2 Incentivizing the Delivery of the Right Care in the Right Place at the Right Time

Aligned with LDH's Quality Strategy and incentive-based quality measures, we design our provider and enrollee incentives to improve the timeliness and quality of care, increase engagement in preventive services and screenings, inspire behavior change among our enrollees, and reward providers for value.

Provider Incentives to Foster the Delivery of the Right Care in the Right Place at the Right Time

Humana's provider incentives, outlined in **Table 2.6.11.2-2**, promote whole-person, integrated care (including SDOH screenings and referrals), close care gaps, and reduce PPEs. **Our provider incentives are effective: Our Valued-Care+ VBP models lead to 25.3% fewer ED visits and 17.4% fewer inpatient admissions per 1,000 enrollees among our Florida Medicaid risk providers than their non-risk peers**.

[redacted] for SDOH needs, coding of Z codes, and referrals to services; we offer additional incentives for timely referral closure.

[redacted]

2.6.11.2.3 Evidence-Based Interventions and Strategies Targeting Super-Utilizers and Reducing Potentially Preventable Events

Quality Excellence

Our approach effectively manages super-utilizers. Since 2016, our strategies have **reduced nonemergent admissions by 47%, readmissions by 38.7%, and ED visits by 8.3% per 1,000** for high utilizers in our Florida Medicaid market.

We initiate and underpin our strategies with continuous data analytics where our quality, analytics, clinical, pharmacy, and UM teams monitor clinical data to pinpoint super-utilizers. Enabled by HIT and data interoperability efforts, our robust set of actionable reports (i.e., Inpatient Census Report, Early Indicator Report, 3M PPE Report, High Utilizer Report, and proprietary predictive models) integrates quality, claims, authorization, and utilization data to generate an enrollee risk score and reveal super-utilizers and those at high risk of inappropriate ED use. These high-precision analyses trigger automatic alerts and prompt evidence-based strategies shown in **Table 2.6.11.2-3**:

2.6.11.3 Improving the Health Status of Covered Populations

Our multidisciplinary QAPI program draws upon our robust set of actionable metrics, clinical dashboards, and analytics tools to continuously monitor, measure, and evaluate the effectiveness of our quality activities. We use these insights to identify performance improvement opportunities; establish baselines; and implement, assess, and adjust targeted evidence-based interventions to maximize improvement in outcomes and health equity. Recognizing our provider partners are essential in this process, we share timely and actionable data to enhance clinical decision-making; **our connection with eight of the top EHR vendors, including Epic, fosters real-time data sharing with our providers**. We employ the following processes to identify quality of care issues, care gaps, and disparities in outcomes:

- **Data Stratification to Identify Health Disparities** by race, ethnicity, language, disability status, geographic region (rural and urban), gender identity, and age into all quality performance analytics
- **Analysis of Access and Availability Issues** including after-hours availability of providers
- **Analysis of Continuity and Coordination of Care Activities**
- **Review of Other Nonclinical Areas of Performance**, such as call center statistics, marketing and outreach, claims processing timeliness and accuracy, and enrollee and provider satisfaction

Quality Excellence

Humana's QI strategies are successful: Between 2019 and 2020, **more than 100 HEDIS measures achieved a rate improvement**, comprising over 70% of reported measures in the Effectiveness of Care and Access & Availability domains in our Kentucky Medicaid market.

Example: Data-Driven Initiative Initiated Within Last 24 months that Yielded Improvements

In alignment with Florida Medicaid's priority of improving birth outcomes, Humana implemented a Performance Improvement Project (PIP) aimed at reducing C-sections and preterm deliveries in 2019, reflected in **Table 2.6.11.3-1**.

Table 2.6.11.3-1: Plan-Do-Study-Act (PDSA) – Holistic Care Initiative to Improve Birth Outcomes
Plan: As the first step on the PDSA cycle, our barrier analysis revealed enrollees required increased education on the availability of Care Management activities and programming. We identified all Medicaid eligible enrollees and used our predictive modeling capabilities, inclusive of physical health and BH variables, to stratify enrollees based on future risk and high cost and to prioritize ongoing outreach and engagement in our Moms First CM program.
Do: We implemented the following interventions to educate and engage enrollees and providers in our proven strategies: 1) **Multichannel, comprehensive education campaign** via new mother engagement kits, mail, email and social media campaigns and our Case Managers; 2) **promoting enrollment in Moms First** with individualized support from a dedicated Case Manager and tailored education. Enrollees complete a social needs assessment to identify and address social needs that may affect carrying out a healthy pregnancy; 3) **increasing the use of LARC** to reduce birth complications by offering the service at no up-front cost and educating providers on how to bill for services; 4) **doula services** to enrollees as a value based benefit, including five prenatal and three postpartum visits and coaching on normal vaginal delivery and vaginal birth after a C-section; 5) **maternal home visiting programs** to monitor blood pressure, preeclampsia, glucose, weight, and pitting edema and to administer fluids for hyperemesis; and 6) **OB/GYN incentives** for early identification of pregnant enrollees, providing LARC, increased rates of prenatal and postpartum visits, and decreased rates of C-sections and preterm deliveries.
Study: Throughout this PIP, we continuously monitored two indicators (the C-section rate and preterm delivery rate) via work groups, task forces, and our QAPI Committee. Our interventions effectively reduced C-section and preterm deliveries, as demonstrated under "Results," engaged enrollees where we **achieved a 7.6% increase in engagement in our Moms First program**, and enabled providers to close maternal healthcare gaps.
Act: Our ongoing analyses reveal continued improvements with birth outcomes. Positive provider and enrollee feedback support the continuation and scaling of our interventions to address further disparities.
Results: Through these interventions, we **decreased the C-section rate by 6.2%** in our Florida Medicaid program in 2020; we **reduced preterm deliveries by 21.9%** for Moms First enrollees during this period. Further, we **decreased NICU days/admits by 15.8% and NICU cost/admits by 22.4%**. We will incorporate these proven strategies into our maternal health programs for Louisiana Medicaid.

2.6.11.3.1 Analyzing Gaps in Delivery of Services for Improved Management of Chronic and Acute Conditions and Reducing Disparities in Health Outcomes

Enabled by advanced analytics and interoperable technology solutions, our data-driven QAPI program generates multilevel, actionable reports across enrollee, provider, community, and population levels. Our quality associates use these insights, generated from tools outlined in **Table 2.6.11.3-2** and enrollee and provider feedback, to 1) identify gaps and disparities in service delivery and quality of care; 2) perform barrier, root cause, and gap analyses to understand nuances, including SDOH, leading to poor outcomes and disparities; and 3) implement targeted, evidenced-based improvement strategies.

[redacted]

Incorporating Feedback from our Enrollees and Providers

Appreciating the value in gaining insights from diverse perspectives, **Humana continuously collects and incorporates enrollee and provider feedback into our QM/QI activities**. Through standardized feedback channels, we integrate enrollee and provider input from multiple sources, such as our Enrollee Advisory Council, Provider Advisory Council (PAC), provider surveys, and CAHPS survey, in our root cause analyses to better understand the nuances leading to disparities. To support ongoing collection of enrollee and provider feedback, we conduct our enrollee Pulse Simulation Survey and Culturally and Linguistically Appropriate Services (CLAS) Survey and perform mid-year provider surveys.

Quality Excellence

Integrating enrollee feedback is critical to driving quality and improving the enrollee experience at Humana. During one of our Kentucky Medicaid Enrollee Advisory Council meetings, an enrollee suggested Humana cover eyeglasses for adults, a benefit not covered by Kentucky Medicaid. Our local Benefits Review Committee, which meets quarterly, performed an analysis based on the enrollee's feedback and determined to add an adult vision benefit, including glasses (frames and lenses), every two years as a VAB.

2.6.11.3.2 Identifying Underlying Reasons for Variations in the Provision of Care to Enrollees

Once we identify gaps in care delivery, quality of care issues, and/or disparities in outcomes, we perform multiple statistical and root cause analysis techniques to determine why an issue occurred. A crucial part of our process, these analyses allow us to understand an issue fully and create a targeted solution to resolve the issue and prevent recurrence. [redacted]

2.6.11.3.3 Implementing Improvement Strategies Related to Analytical Findings

Based on our analytical findings described above, Humana employs the PDSA data-driven improvement process, illustrated in **Figure 2.6.11.3-2,** to implement our QM/QI strategies. Widely promoted by the International Health Institute (IHI), this iterative process unites rapid-cycle improvement methods, rigorous measurement and evaluation, targeted enrollee and provider interventions, and high-touch supports to improve and sustain health outcomes. This proven approach results in measurable improvement in our Medicaid programs, as seen by our consistent HEDIS improvement. **Between 2019 and 2020, we saw a 23% increase in the number of measures achieving a rate improvement and an 8% increase in the number of measures reaching the 90th percentile in our Kentucky Medicaid program**.

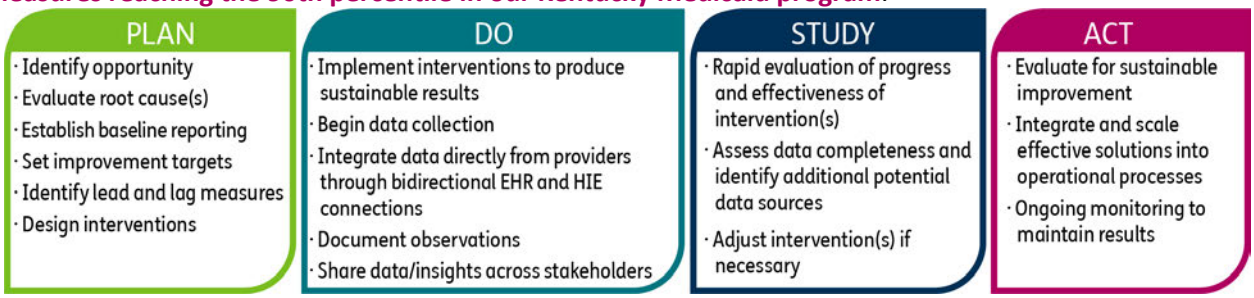


Figure 2.6.11.3-2: The iterative PDSA process fosters a quality culture of CQI.

2.6.11.4 Approach to Quality Management and Quality Improvement

Guided by best practice, Humana integrates all functional areas impacting quality of care and synchronizes their activities to identify areas of opportunity; implement, assess, and adjust evidence-based QI activities; follow CQI methodologies; and remain responsive to current, emerging, and evolving enrollee needs. Our proven Quality Management (QM) framework and committee structure facilitates cross-functional forums that continuously monitor, measure, and evaluate our performance and QI efforts while also fostering the sharing of best practices and lessons learned across all plans and functional areas.

2.6.11.4.1 Quality Management/Quality Improvement Organizational Plan Description

Aligned with the Agency for Healthcare Research and Quality's National Quality Strategy, our **QI Plan Description** (QIPD) establishes QM/QI goals to be monitored, evaluated, and achieved by our QAPI program. The QIPD outlines our market and enterprise resources to support quality; defines systematic approaches to measurement and evaluation; and describes the collaboration needed among integrated functional areas to achieve our overarching goal of improving the quality of care and delivery of service.

QM/QI Organizational Goals

Incorporating CMS's goals and LDH's Quality Strategy, our overarching goal is to improve the quality of care and delivery of service via our comprehensive approach to quality, outlined in **Table 2.6.11.4-1**:

Table 2.6.11.4-1: Goals of Humana's Louisiana Medicaid QM/QI and QAPI Programs
Develop clinical and quality strategies that look at the whole person and integrate physical health and BH care.
Provide practitioners with comparative and actionable data regarding quality and health outcomes to identify opportunities and support achievement of population health goals.
Ensure a holistic strategy for population health and health equity that addresses enrollee physical health, BH, and SDOH needs across the care continuum.
Provide solutions for enrollees with complex needs and chronic conditions to achieve optimal health outcomes.
Monitor and promote the safety of clinical care and service.

QM/QI Organizational Multidisciplinary Committees Ensure a Holistic Approach to QM/QI

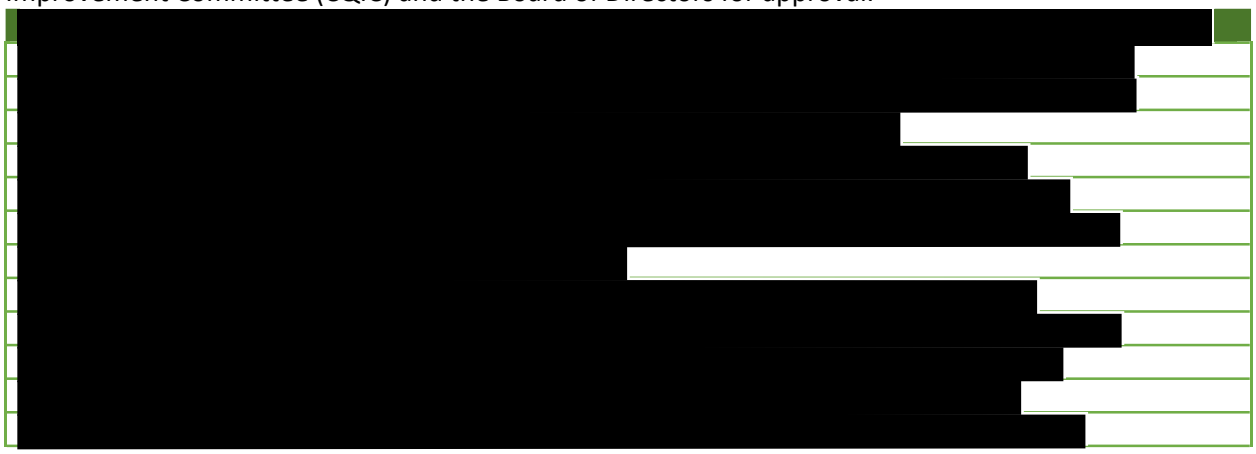
Our Louisiana QAPI Committee will direct, review, and evaluate all QAPI programming, associates, committees, and initiatives. To foster comprehensive integration of quality and operational processes, our QAPI Committee is co-chaired by our [redacted] QAPI Committee will meet at least monthly to review and evaluate QI activities; focus discussions on policy,

programs, and quality initiatives; and drive direction toward goals outlined in the QIPD. Our [redacted] will participate on the Louisiana Medicaid Quality Committee and report findings to our QAPI Committee. **We encourage participation from diverse provider types, including performing targeted outreach to BH and rural providers**, and **our CMO personally invites providers to join our QAPI Committee**. We maintain a representative QAPI Committee with participants including providers; advanced practice nurses; and Humana clinical associates from areas such as grievance and appeals (G&A), Care Management, medical management, and compliance. **The QAPI Committee will maintain direct oversight over the following Louisiana-based committees**, outlined in **Table 2.6.11.4-2**, ensuring the direct incorporation of feedback into our QM/QI activities while increasing accountability and integration:

Table 2.6.11.4-2: Humana's Louisiana Medicaid Committees Reporting to the QAPI Committee
Enrollee Advisory Council: Co-chaired by an enrollee (Humana best practice) and our Culture & Community Engagement Director (CCED), we convene enrollees, their families, and enrollee community advocates each quarter to obtain feedback about their experience. Our CCED reports feedback as potential QI activities directly to our QAPI Committee. To engage enrollees, we host events with trusted community partners and at times convenient for enrollees. We will offer our Louisiana Medicaid enrollee reimbursement for Enrollee Advisory Council related expenses.
PAC: With diverse provider representation, this forum obtains provider feedback to improve services, address concerns, inform our education strategy, and drive QI activities. We will ensure participation in our PAC from a variety of provider types, including BH providers, pharmacists, and at least one provider representative from each State region, to ensure our program responds to feedback from our integrated network.
Peer Advisory Committee: This monthly forum convenes our CMO, PCPs, specialists, BH providers, psychiatrists, and our Quality Operations, Compliance, and Accreditation (QOCA) director and associates to review clinical quality concerns, develop individual provider QI plans, and review progress until resolution.
UM Committee: This integrated forum monitors, analyzes, and trends utilization data to identify outliers, create improvement plans for appropriate utilization, and reports updates and progress to the QAPI Committee.

QM/QI Organizational Schedule of QM Activities

Our QI Work Plan (QIWP) specifies the schedule, time frame, and responsible party for executing QM/QI activities. The QIWP outlines monitoring, evaluation, and reporting cycles to foster continuous analysis of the quality and appropriateness of delivered care, including integrated care and care delivered to enrollees with special health care needs (SHCN). **We perform more than 50 monitoring and reporting activities throughout the year** with examples outlined in **Table 2.6.11.4-3**. The QIWP integrates Quality Improvement Evaluation (QIE) feedback and will incorporate our **Provider Support Plan** and **Health Equity Plan**. The QAPI Committee approves and monitors the QIPD, QIWP, and QIE and submits these to our Corporate Quality Improvement Committee (CQIC) and the Board of Directors for approval.



2.6.11.4.2 Quality Management/Quality Improvement Program Organizational Chart

Humana's QM/QI organizational structure consists of Louisiana-based quality associates supported by robust enterprise resources. This approach unites best practices, infrastructure, and insights to foster the delivery of high-quality care. The Humana Board of Directors is ultimately accountable for our quality

program. [redacted] will direct our QM/QI activities. Our organizational chart, depicted in **Figure 2.6.11.4-1**, illustrates Humana's departments and committees involved in ensuring a comprehensive approach to quality.

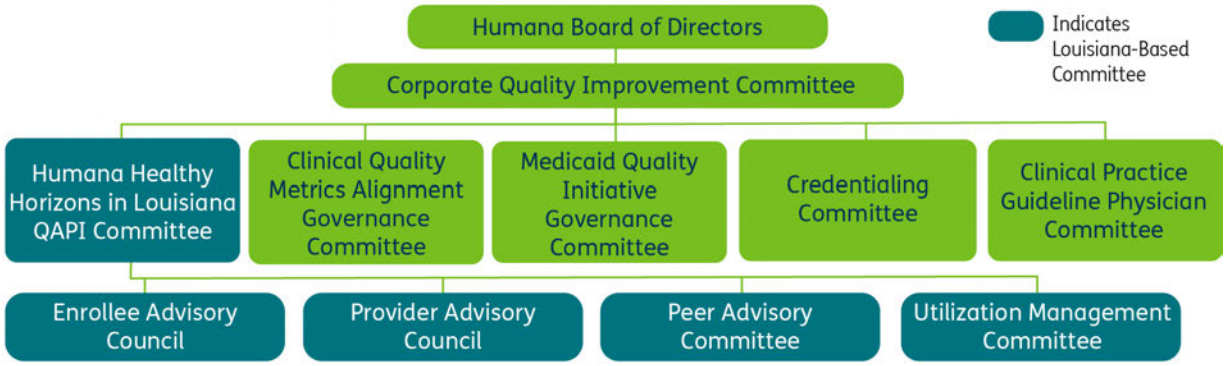


Figure 2.6.11.4-1: Our QM/QI structure unites best practices, insights, and robust enterprise resources.

Our Louisiana Medicaid leadership and Quality associates will receive IHI quality training and have the opportunity to complete our Certified Professional in Healthcare Quality pathway. The following Louisiana-based associates, outlined in **Table 2.6.11.4-4**, are responsible for our QM/QI program.

[redacted]

2.6.11.4.3 Participation in LDH's annual HEDIS® measurement and reporting initiatives

Humana has the capabilities and resources available to participate in LDH's annual HEDIS measurement and reporting initiative. **Table 2.6.11.4-5** reflects our commitment to quality measures. **We have been monitoring, tracking, and reporting NCQA Medicaid HEDIS measures in our Florida Medicaid plan for more than 20 years and in our Kentucky Medicaid plan for nine years; we report HEDIS measures for our MA plans across all 50 states**. Our Quality Systems and Integration (QSI) team oversees our HEDIS quality reporting, using our NCQA accredited rules engine, Cotiviti, to support HEDIS reporting for operational and official applications. We conduct prospective measure analysis to support interim reporting in addition to the annual official submissions.

[redacted]

Availability of Dedicated Resources

Our Louisiana-based P/QIC will oversee local HEDIS reporting capabilities with support from our national HEDIS team to ensure timely and accurate data reporting. **We will have more than 30 associates supporting Louisiana Medicaid HEDIS measurement and reporting and additional quality metrics**.

2.6.11.4.4 Example of Recent Successful Quality Improvement Activity: Promoting VBP (2019)

Aligned with our commitment to promote value-based care and improve quality of care, Humana implemented a QI activity in our Florida Medicaid program, shown in **Table 2.6.11.4-6** to help one of our largest independent physician groups, Health First Network, with more than 30,000 attributed Humana enrollees, successfully transition from fee-for-service to a value-based care model in 2019.

[redacted]

[redacted]

2.6.11.4.5 Identifying Quality Improvement Plans and Projects

Our [redacted] will work with Louisiana Medicaid leadership to develop, implement, and monitor clinical and nonclinical improvement projects that consider 1) priority areas identified by Humana, LDH, and providers; 2) the prevalence of a condition in the population; 3) enrollee demographics, health risks, and **disparities in outcomes**; and 4) the interest and satisfaction of enrollees and/or providers. Based on quantitative and qualitative data-driven decision-making, we identify benchmarks and **set achievable performance goals** for each PIP we implement. Data sources for initial PIP development, goal setting, and benchmark establishment include the current and previous years' HEDIS and quality measure results; national standards and benchmarks; and claims, utilization, CAHPS, enrollee satisfaction, Care Management, clinical, and population health data. Our [redacted], will review and approve topics and PIP proposals.

Potential Quality Improvement Plan and Projects Topics

We will collaborate with LDH to identify and implement at least three PIPs, at least one having BH focus. Based on current LDH performance and alignment with Louisiana's Quality Strategy, potential topic areas for Year 1 initiatives include, but are not limited to: 1) BH post-acute care coordination, 2) cervical and colorectal cancer screenings, 3) well-child visits, 4) maternal outcomes, and 5) pediatric oral health.

Monitoring Implementation and Outcomes of Activities

Informed by best practice, we monitor PIP performance via task forces, subcommittee meetings, and QAPI Committee oversight. Following CQI practices, we employ the PDSA improvement cycle to monitor PIPs throughout their lifecycle. The iterative nature of this approach yields **continuous monitoring, measurement, evaluation, and adjustment of our QM/QI activities** where our Louisiana-based quality and analytics teams, leadership team, and QAPI Committee will review actionable reports on established daily, weekly, monthly, quarterly, and annual intervals. This frequency enables us to monitor and identify stagnating or declining outcomes, perform rapid cycle root cause analyses, and intervene promptly with adjusted strategies, ensuring our PIPs achieve performance goals and improve quality of care. This approach allows us to test innovations and scale effective solutions across Medicaid programs.

2.6.11.5 Clinical Practice Guidelines Relevant to LDH Medicaid Population

Humana adopts and shares evidence-based Clinical Practice Guidelines (CPG) that reflect the unique needs of the populations we serve. Based on valid, clinical evidence, our comprehensive CPGs integrate provider input, prioritize enrollee physical health and BH needs, and are reviewed systematically. This approach fosters the consistent delivery of high-quality care, leading to improved outcomes, integrated care delivery, and the reduction of low value care. **Table 2.6.11.5** highlights CPGs relevant to the LDH Medicaid population.

Table 2.6.11.5: Humana's Comprehensive CPGs Relevant to the LDH Medicaid Population
BH: Assessment and Treatment of Children and Adolescents With **Attention-Deficit/Hyperactivity Disorder**; Identification, Evaluation, and Management of Children With **Autism Spectrum Disorder**; Treatment of Patients With **Bipolar Disorder**; Major **Depression** in Adults in Primary Care Guideline; Diagnosis and Management of **Generalized Anxiety Disorder and Panic Disorder** in Adults; Pain: Assessment, **Non-Opioid Treatment** Approaches and **Opioid Management** Care for Adults; **Oppositional Defiant Disorder**; Management of **Post-Traumatic Stress Disorder and Acute Stress Disorder**; Treatment of Patients With **Schizophrenia**; Assessment and Treatment of **Children and Adolescents With Substance Use Disorders**; Treatment of Patients With **Substance Use Disorders**; Assessment and Treatment of Patients with **Suicidal Behaviors**
Chronic Conditions: Global Strategy for **Asthma** Management and Prevention; Management of Patients with **Atrial Fibrillation**; Management of **Blood Cholesterol**; Primary Prevention of **Cardiovascular Disease**; Guidelines on the Assessment of **Cardiovascular Risk**; Global Strategy for the Diagnosis, Management, and Prevention of **Chronic Obstructive Pulmonary Disease**; Standards of Medical Care in **Diabetes**; Management of **Heart Failure**; Global **Hypertension** Practice Guidelines; Adult Acute and Subacute **Low Back Pain**; Evidence-Based Management of **Sickle Cell Disease**; Management of Patients with **Valvular Heart Disease**
COVID-19: Coronavirus Disease 2019 (**COVID-19**) Treatment Guidelines
Prenatal and Postnatal Care: Guidelines for **Perinatal Care**, Recommendations for **Well-Woman Care**
Preventive Health: Recommended **Adult Immunization** Schedule, Recommended **Child and Adolescent Immunization** Schedule, Bright Futures **Periodicity Schedule** (EPSDT), U.S. Preventive Services Prevention Task Force A-Z **Preventive Care and Screenings** Recommendations, Recommendations for **Well-Woman Care**

Sample Clinical Practice Guideline

Please refer to **Attachment 2.6.11.5 CPG Sample** for our hypertension sample guideline.

2.6.11.5.1 Collaborating to Develop and Disseminate Clinical Practice Guidelines

Developing CPGs: Humana employs a centralized and collaborative approach to developing CPGs, facilitating a uniform dissemination of CPGs and keeping CPGs rooted in evidence-based practices. Twice each year, Humana's representative CPG Committee (CPGC) convenes providers from diverse specialty and BH backgrounds to research, review, and revise selected guidelines. The CPGC incorporates provider and enrollee insight obtained from our PAC and reported to our QAPI Committee, ensuring our CPGs address key drivers impacting our enrollees and providers. The CPGC draws upon the expertise of our national Quality Operations, Compliance, and Accreditation (QOCA) department and can meet on ad hoc basis when needed such as in 2020 when the CPGC convened more frequently to adopt COVID-19 guidelines. **We will convene and coordinate with LDH and other selected MCOs through collaborative work groups to ensure consistency of CPGs across plans to reduce provider administrative burden**.

- **Disseminating to Providers:** Via the provider portal, provider manual, and Humana website
- **Disseminating to Enrollees:** Via the enrollee handbook, enrollee services, and Humana website

2.6.11.5.2 Incorporating Scientific Evidence and Expert Opinions into Clinical Practice Guidelines

As the foundation of our written policies and procedures on medical decision-making, Humana adopts evidence-based, nationally accepted standards and guidelines from clinically sound and reputable organizations, such as the Agency for Healthcare Research and Quality, American Diabetes Association, Centers for Disease Control and Prevention, NCQA, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, and American Society of Addiction Medicine. We develop CPGs in consultation with network providers and out-of-network experts, who participate on the CPGC. **We will seek clinical policy and provider operations input from our Louisiana providers via our PAC**.

2.6.11.5.3 Evaluating Providers' Adherence to Clinical Practice Standards and Evidence-Based Practice

Our QOCA team monitors our **CPG Adherence (CPGA) Report** to identify outliers based on certain thresholds, conduct a focused review, and coordinate interventions. The Louisiana QAPI Committee will review follow-up activities in quarterly reports. In addition, Humana performs continuous **care gap reporting**, which includes measures related to CPGs, to monitor provider performance; and our **comprehensive medical records review** assesses provider compliance to EPSDT-related CPGs.

[redacted]

2.6.11.5.4 Evaluating, Updating, and Revising CPGs for Consistency with Medical Practice Standards

Our QOCA team works with leading physicians from diverse specialties to conduct thorough, semiannual literature reviews to evaluate, update, and revise CPGs. We present proposed CPGs to our CQIC for approval and communicate to our market-based QAPI Committee for adoption and implementation. As soon as we update guidelines, we post notifications on our public-facing webpage and update provider educational materials. Humana provides timely written notice for cancelled or materially changed guidelines with our Provider Relations Representatives and PPIAs performing in-person provider education and trainings. In Louisiana, we will incorporate provider feedback from our PAC to ensure CPGs conform to medical practice standards and to determine if additional updates or additions are necessary.

2.6.11.6 NCQA Health Insurance Plan Ratings

Please see **Attachment 2.6.11.6 Humana's Quality Response Template** for our health insurance ratings.

2.6.11.7 NCQA Accreditation Certificates

Please see **Attachment 2.6.11.7-1 NCQA Accreditation FL, Attachment 2.6.11.7-2 NCQA Accreditation KY,** and **Attachment 2.6.11.7-3 NCQA Accreditation SC** for copies of our Medicaid NCQA accreditation certificates. Upon execution of the contract, Humana will apply for full accreditation status in Louisiana. We will adhere to the timeline outlined in **Table 2.6.11.7** with full accreditation status slated for receipt by December 2023. This timeline enables us to align all lines of business present in Louisiana and ensure NCQA compliance across all policies and procedures. We will also pursue the **NCQA Health Equity Accreditation Plus** to coincide with our NCQA health plan accreditation. This distinction aligns with Humana values and reinforces our core mission and enterprise goals. We are confident our resources, commitment to quality, and experience receiving NCQA accreditation will facilitate a swift accreditation process as demonstrated by our recent NCQA accreditation in our South Carolina Medicaid program where our timeline and abilities enabled us to create NCQA-compliant processes and documentation quickly prior to going live.

Table 2.6.11.7: Timeline for Activities

Task	Date
Louisiana Medicaid health plan goes live	July 1, 2022
Apply for NCQA Full Accreditation and NCQA Health Equity Accreditation Plus	January 2023
Submit NCQA Survey Tool with Documentation	September 2023
Respond to Follow-up Questions from NCQA	October 2023
On-site Survey - File Reviews	November 2023
Receive Notifications for Full Accreditation Status	December 31, 2023

2.6.11.8 Material Subcontractor NCQA Information

Humana deploys a **fully integrated clinical delivery model** in which we provide BH services in-house. BH services will fall within the scope of Humana's Louisiana Medicaid NCQA Health Plan Accreditation.

2.6.11 Quality

Attachment 2.6.11.5 CPG Sample
Attachment 2.6.11.6 Humana's Quality Response Template
Attachment 2.6.11.7-1 NCQA Accreditation FL
Attachment 2.6.11.7-2 NCQA Accreditation KY
Attachment 2.6.11.7-3 NCQA Accreditation SC

Clinical Practice Guidelines

2020 International Society of Hypertension Global Hypertension Practice Guidelines

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Table of Contents

Section 1. Introduction....1334
Section 2. Definition of Hypertension....1336
Section 3. Blood Pressure Measurement and Diagnosis of Hypertension....1336
Section 4. Diagnostic and Clinical Tests....1337
Section 5. Cardiovascular Risk Factors....1339
Section 6. Hypertension-Mediated Organ Damage....1340
Section 7. Exacerbators and Inducers of Hypertension....1341
Section 8. Treatment of Hypertension....1341
8.1 Lifestyle Modification....1341
8.2 Pharmacological Treatment....1341
8.3 Adherence to Antihypertensive Treatment....1341
Section 9. Common and Other Comorbidities of Hypertension....1342
Section 10. Specific Circumstances....1346
10.1 Resistant Hypertension....1346
10.2 Secondary Hypertension....1346
10.3 Hypertension in Pregnancy....1347
10.4 Hypertensive Emergencies....1348
10.5 Ethnicity, Race and Hypertension....1350
Section 11. Resources....1350
Section 12. Hypertension Management at a Glance....1352
Acknowledgments....1354
References....1354

Section 1: Introduction

Context and Purpose of This Guideline

Statement of Remit

To align with its mission to reduce the global burden of raised blood pressure (BP), the International Society of Hypertension (ISH) has developed worldwide practice guidelines for the management of hypertension in adults, aged 18 years and older.

The ISH Guidelines Committee extracted evidence-based content presented in recently published extensively reviewed guidelines and tailored ESSENTIAL and OPTIMAL standards of care in a practical format that is easy-to-use particularly in low, but also in high resource settings – by clinicians, but also nurses and community health workers, as appropriate. Although distinction between low and high resource settings often refers to high (HIC) and low- and middle-income countries (LMIC), it is well established that in HIC there are areas with low resource settings, and vice versa.

Herein optimal care refers to evidence-based standard of care articulated in recent guidelines[1,2] and summarized here, whereas ESSENTIAL standards recognize that OPTIMAL standards would not always be possible. Hence essential standards refer to minimum standards of care. To allow specification of essential standards of care for low resource settings, the Committee was often confronted with the limitation or absence in clinical evidence, and thus applied expert opinion.

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Abbreviations

ABI	ankle-brachial index
ABPM	ambulatory blood pressure monitoring
ACE	angiotensin converting enzyme
ARB	angiotensin AT-1 receptor blocker
ARNI	angiotensin receptor-neprilysin inhibitors
BMI	body mass index
BP	blood pressure
CAD	coronary artery disease
CCBs	calcium channel blockers
CKD	chronic kidney disease
COPD	chronic obstructive pulmonary disease
CVD	cardiovascular disease
DBP	diastolic blood pressure
DHP-CCB	dihydropyridine calcium channel blocker
DM	diabetes mellitus
DRI	direct renin inhibitor
ECG	electrocardiogram
eGFR	estimated glomerular filtration rate
ESC-ESH	European Society of Cardiology, European Society of Hypertension
HBPM	home blood pressure measurement
HDL	high density lipoprotein
HELLP	hemolysis, elevated liver enzymes and low platelets
HF	heart failure
HFpEF	heart failure with preserved ejection fraction
HFrEF	heart failure with reduced ejection fraction
HIC	high-income countries
HIIT	high intensity interval training
HIV	human immunodeficiency virus
HMOD	hypertension-mediated organ damage
IMT	intima media thickness
IRD	inflammatory rheumatic disease
ISH	International Society of Hypertension
LDH	lactate dehydrogenase
LDL-C	low-density lipoprotein cholesterol
LMIC	low- and middle-income countries
LV	left ventricular
LVH	left ventricular hypertrophy
MAP	mean arterial pressure
MRI	magnetic resonance imaging
MS	metabolic syndrome
NSAIDs	nonsteroidal anti-inflammatory drugs
PWV	pulse wave velocity
RAAS	renin angiotensin aldosterone system
RAS	renin-angiotensin system
RCT	randomized control trials
SBP	systolic blood pressure
SNRI	selective norepinephrine and serotonin reuptake inhibitors
SPC	single pill combination therapy
SRI	serotonin reuptake inhibitors
SSRI	selective serotonin reuptake inhibitors
s-UA	serum uric acid
T4	thyroxin 4
TIA	transient ischemic attack
TMA	thrombotic microangiopathy
TSH	thyroid stimulating hormone
TTE	two-dimensional transthoracic echocardiogram
UACR	urinary albumin creatinine ratio

In the Guidelines, differentiation between optimal and essential standards were not always possible, and were made in sections where it was most practical and sensible. The Guidelines Committee is also aware that some recommended essential standards may not be feasible in low resource settings, for example, out-of-office BP measurements, the requirement of multiple visits for the diagnosis of hypertension, or advising the use of single pill combination therapy. Although challenging to implement, these guidelines may aid in local initiatives to motivate policy changes and serve as an instrument to drive local improvements in standards of care. Every effort should be made to achieve essential standards of care to reduce hypertension-induced cardiovascular morbidity and mortality.

Motivation

Raised BP remains the leading cause of death globally, accounting for 10.4 million deaths per year.[3] When reviewing global figures, an estimated 1.39 billion people had hypertension in 2010. [4] However, BP trends show a clear shift of the highest BPs from high-income to low-income regions,[5] with an estimated 349 million with hypertension in HIC and 1.04 billion in LMICs.[4]

The large disparities in the regional burden of hypertension are accompanied by low levels of awareness, treatment and control rates in LMIC, when compared to HIC. In response to poor global awareness for hypertension (estimated 67% in HIC and 38% in LMIC),[4] the ISH launched a global campaign to increase awareness of raised BP, namely the May Measurement Month initiative.[6,7]

Despite several initiatives, the prevalence of raised BP and adverse impact on cardiovascular morbidity and mortality are increasing globally, irrespective of income.[4,5] It is therefore critical that population-based initiatives are applied to reduce the global burden of raised BP, such as salt-reduction activities and improving the availability of fresh fruit and vegetables. To improve the management of hypertension, the ISH has published in 2014 with the American Society of Hypertension, Clinical Practice Guidelines for the Management of Hypertension in the Community (See Section 11: Resources). Recently, we have observed a recent flurry of updated evidence-based guidelines arising mainly from high-income regions and countries, including the United States of America,[2] Europe,[1] United Kingdom,[8] Canada[9] and Japan.[10] New developments include redefining hypertension,[2] initiating treatment with a single pill combination therapy,[1]

Table 1. Classification of Hypertension Based on Office Blood Pressure (BP) Measurement

Category	Systolic (mm Hg)		Diastolic (mm Hg)
Normal BP	<130	and	<85
High-normal BP	130–139	and/or	85–89
Grade 1 hypertension	140–159	and/or	90–99
Grade 2 hypertension	≥160	and/or	≥100

Table 2. Criteria for Hypertension Based on Office-, Ambulatory (ABPM)-, and Home Blood Pressure (HBPM) Measurement

	SBP/DBP, mm Hg
Office BP	≥140 and/or ≥90
ABPM	
24-h average	≥130 and/or ≥80
Day time (or awake) average	≥135 and/or ≥85
Night time (or asleep) average	≥120 and/or ≥70
HBPM	≥135 and/or ≥85

advising wider out-of-office BP measurement,[2,10] and lower BP targets.[1,2,8,11,12]

Low- and middle-income regions often follow the release of guidelines from high-income regions closely, as their resources and health systems to develop and implement local guidelines remain challenging. In Africa only 25% of countries have hypertension guidelines[13] and in many instances these guidelines are adopted from those of high-income regions. However, the adoption of guidelines from high-income regions are sometimes impractical as low resource settings are confronted with a substantial number of obstacles including severe lack of trained healthcare professionals, unreliable electricity in rural clinics, low access to basic office BP devices and limited ability to conduct basic recommended diagnostic procedures and poor access to affordable high-quality medications. In both low and high-income regions, the ambiguities of latest guidelines are often met with confusion among healthcare providers, anxiety among patients,[14] and they resulted in a call for global harmonization.[15] Guidelines from high-income regions may thus not fit global purpose.[16]

Guideline Development Process

The 2020 ISH Global Hypertension Practice Guidelines were developed by the ISH Hypertension Guidelines Committee based on evidence criteria, (1) to be used globally; (2) to be fit for application in low and high resource settings by advising on essential and optimal standards; and (3) to be concise, simplified, and easy to use. They were critically reviewed and evaluated by numerous external hypertension experts from HIC and LMIC with expertize in the optimal management of hypertension and management in resource-constraint settings. These Guidelines were developed without any support from industry or other sources.

Composition of the ISH Hypertension Guidelines Committee and Selection of External Reviewers

The ISH Hypertension Guidelines Committee was composed of members of the ISH Council; they were included on the basis of (1) specific expertize in different areas of hypertension; (2) previous experience with the generation of hypertension guidelines, as well as (3) representation of different regions of the world. A similar strategy was followed concerning the selection of external reviewers with particular consideration of representatives from LMICs.

Section 2: Definition of Hypertension

- In accordance with most major guidelines it is recommended that hypertension be diagnosed when a person's systolic blood pressure (SBP) in the office or clinic is ≥140 mm Hg and/or their diastolic blood pressure (DBP) is ≥90 mm Hg following repeated examination (see below, Section 3). Table 1 provides a classification of BP based on office BP measurement, Table 2 provides ambulatory and home BP values used to define hypertension; these definitions apply to all adults (>18 year old). These BP categories are designed to align therapeutic approaches with BP levels.
- High-normal BP is intended to identify individuals who could benefit from lifestyle interventions and who would receive pharmacological treatment if compelling indications are present (see Section 9).
- Isolated systolic hypertension defined as elevated SBP (≥140 mm Hg) and low DBP (<90 mm Hg) is common in young and in elderly people. In young individuals, including children, adolescents and young adults, isolated systolic hypertension is the most common form of essential hypertension. However, it is also particularly common in the elderly, in whom it reflects stiffening of the large arteries with an increase in pulse pressure (difference between SBP and DBP).
- Individuals identified with confirmed hypertension (grade 1 and grade 2) should receive appropriate pharmacological treatment.
- Details of home-, office- and ambulatory BP measurement techniques are addressed in Section 3.

Section 3: Blood Pressure Measurement and Diagnosis of Hypertension

ESSENTIAL

Hypertension Diagnosis – Office BP Measurement

- The measurement of BP in the office or clinic is most commonly the basis for hypertension diagnosis and follow-up. Office BP should be measured according to recommendations shown in Table 3 and Figure 1.[1,2,17,18]
- Whenever possible, the diagnosis should not be made on a single office visit. Usually 2–3 office visits at 1–4-week intervals (depending on the BP level) are required to confirm the diagnosis of hypertension. The diagnosis might be made on a single visit, if BP is ≥180/110 mm Hg and there is evidence of cardiovascular disease (CVD).[1,2,17,18]
- The recommended patient management according to office BP levels is presented in Table 4.
- If possible and available, the diagnosis of hypertension should be confirmed by out-of-office BP measurement (see below).[1,2,19–21]

Table 3. Recommendations for Office Blood Pressure Measurement

Conditions	• Quiet room with comfortable temperature.
	• Before measurements: Avoid smoking, caffeine and exercise for 30 min; empty bladder; remain seated and relaxed for 3–5 min.
	• Neither patient nor staff should talk before, during and between measurements.
Positions	• Sitting: Arm resting on table with mid-arm at heart level; back supported on chair; legs uncrossed and feet flat on floor (Figure 1).
Device	• Validated electronic (oscillometric) upper-arm cuff device. Lists of accurate electronic devices for office, home and ambulatory BP measurement in adults, children and pregnant women are available at www.stridebp.org.[22] (see also Section 11: Resources)
	• Alternatively use a calibrated auscultatory device, (aneroid, or hybrid as mercury sphygmomanometers are banned in most countries) with 1st Korotkoff sound for systolic blood pressure and 5th for diastolic with a low deflation rate.[22]
Cuff	• Size according to the individual's arm circumference (smaller cuff overestimates and larger cuff underestimates blood pressure).
	• For manual auscultatory devices the inflatable bladder of the cuff must cover 75%–100% of the individual's arm circumference. For electronic devices use cuffs according to device instructions.
Protocol	• At each visit take 3 measurements with 1 min between them. Calculate the average of the last 2 measurements. If BP of first reading is <130/85 mm Hg no further measurement is required.
Interpretation	• Blood pressure of 2–3 office visits ≥140/90 mm Hg indicates hypertension.

OPTIMAL

Hypertension Diagnosis – Office Blood Pressure Measurement

- **Initial evaluation:** Measure BP in both arms, preferably simultaneously. If there is a consistent difference between arms >10 mm Hg in repeated measurements, use the arm with the higher BP. If the difference is >20 mm Hg consider further investigation.
- **Standing blood pressure:** Measure in treated hypertensives after 1 min and again after 3 min when there are symptoms suggesting postural hypotension and at the first visit in the elderly and people with diabetes.

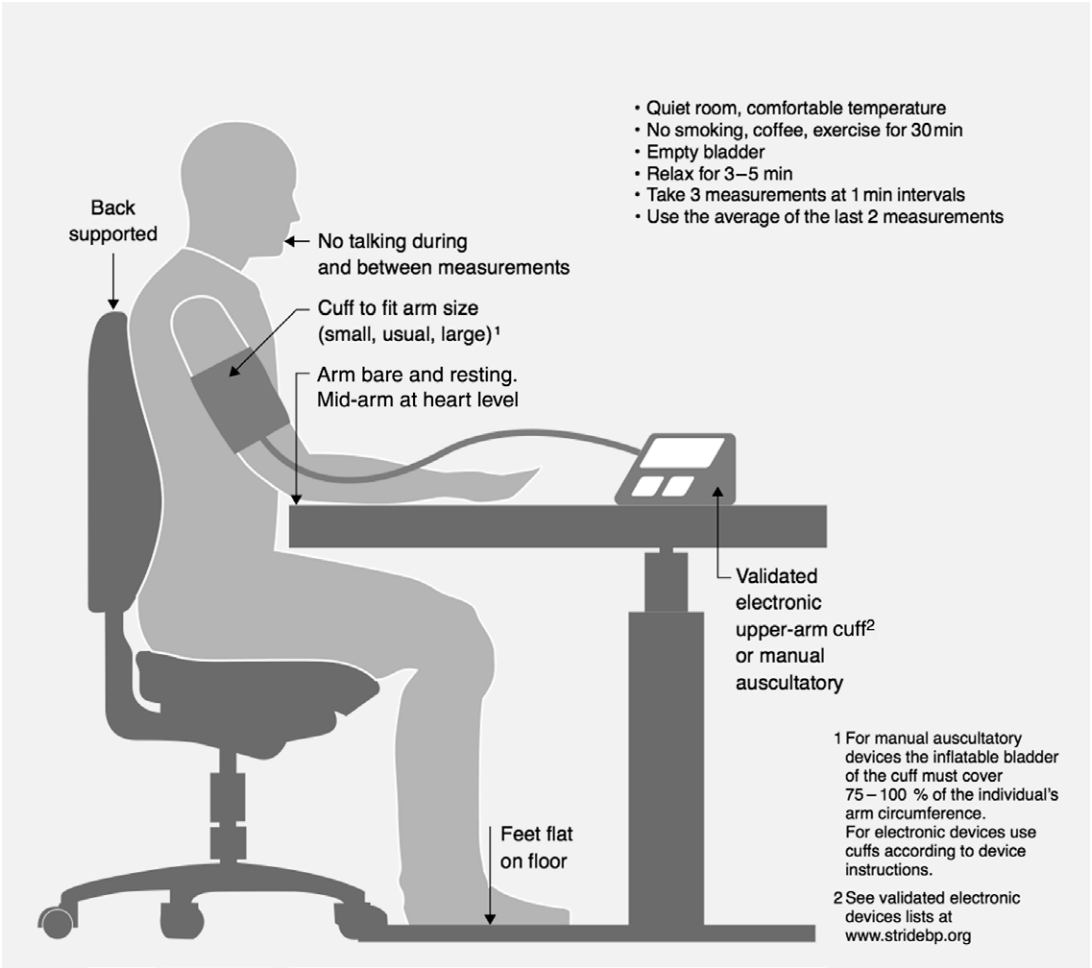

Figure 1. ESSENTIAL How to measure blood pressure.

- **Unattended office blood pressure:** Multiple automated BP measurements taken while the patient remains alone in the office provide a more standardized evaluation but also lower BP levels than usual office measurements with uncertain threshold for hypertension diagnosis.[17,18,23,24] Confirmation with out-of-office BP is again needed for most treatment decisions.

Hypertension Diagnosis – Out-of-Office Blood Pressure Measurement

- Out-of-office BP measurements (by patients at home or with 24-hour ambulatory blood pressure monitoring [ABPM]) are more reproducible than office measurements, more closely associated with hypertension-induced organ damage and the risk of cardiovascular events and identify the white coat and masked hypertension phenomena (see below).
- Out-of-office BP measurement is often necessary for the accurate diagnosis of hypertension and for treatment decisions. In untreated or treated subjects with office BP classified as high-normal BP or grade 1 hypertension (systolic 130–159 mm Hg and/or diastolic 85–99 mm Hg), the BP level needs to be confirmed using home or ambulatory BP monitoring (Table 5).[1,2,17,21]
- Recommendations for performing home and ambulatory BP measurement are presented in Table 5.

White Coat and Masked Hypertension

- The use of office and out-of-office (home or ambulatory) BP measurements identifies individuals with white coat hypertension, who have elevated BP only in the office (nonelevated ambulatory or home BP), and those with masked hypertension, who have nonelevated BP in the office but elevated BP out of the office (ambulatory or home).[1,2,17–21,25–27] These conditions are common among both untreated subjects and those treated for hypertension. About 10%–30% of subjects attending clinics due to high BP have white coat hypertension and 10%–15% have masked hypertension.
- **White coat hypertension:** These subjects are at intermediate cardiovascular risk between normotensives and sustained hypertensives. The diagnosis needs confirmation with repeated office and out-of-office BP measurements. If their total cardiovascular risk is low and there is no hypertension-mediated organ damage (HMOD), drug treatment may not be prescribed. However, they should be followed with lifestyle modification, as they may develop sustained hypertension requiring drug treatment.[1,2,17–21,25–27]
- **Masked hypertension:** These patients are at similar risk of cardiovascular events as sustained hypertensives. The diagnosis needs confirmation with repeated office and out-of-office measurements. Masked hypertension may require drug treatment aiming to normalize out-of-office BP.[1,2,17–21,25–27]

Table 4. Blood Pressure Measurement Plan According to Office Blood Pressure Levels

Office Blood Pressure Levels (mm Hg)		
<130/85	130–159/85–99	>160/100
Remeasure within 3 years (1 year in those with other risk factors)	If possible confirm with out-of-office blood pressure measurement (high possibility of white coat or masked hypertension). Alternatively confirm with repeated office visits.	Confirm within a few days or weeks

Table 5. Clinical Use of Home and Ambulatory Blood Pressure (BP) Monitoring

	Home Blood Pressure Monitoring	24-Hour Ambulatory Blood Pressure Monitoring
Condition	As for office blood pressure (see above).	Routine working day.
Position	As for office BP (see above).	Avoid strenuous activity. Arm still and relaxed during each measurement.
Device	Validated electronic (oscillometric) upper-arm cuff device (www.stridebp.org, and Section 11: Resources)	
Cuff	Size according to the individual's arm circumference	
Measurement protocol	Before each visit to the health professional: • 3–7-day monitoring in the morning (before drug intake if treated) and the evening. • Two measurements on each occasion after 5 min sitting rest and 1 min between measurements. Long-term follow-up of treated hypertension: • 1–2 measurements per week or month.	• 24-hour monitoring at 15–30 min intervals during daytime and nighttime. • At least 20 valid daytime and 7 nighttime BP readings are required. If less, the test should be repeated.
Interpretation	• Average home blood pressure after excluding readings of the first day ≥135 or 85 mm Hg indicates hypertension.	• 24-hour ambulatory blood pressure ≥130/80 mm Hg indicates hypertension (primary criterion). • Daytime (awake) ambulatory blood pressure ≥135/85 mm Hg and nighttime (asleep) ≥120/70 mm Hg indicates hypertension

Section 4: Diagnostic/Clinical Tests

ESSENTIAL

Medical History

Patients with hypertension are often asymptomatic, however specific symptoms can suggest secondary hypertension or hypertensive complications that require further investigation. A complete medical and family history is recommended and should include[1]:

- **Blood pressure:** New onset hypertension, duration, previous BP levels, current and previous antihypertensive medication, other medications/over-the counter medicines that can influence BP, history of intolerance (side-effects) of antihypertensive medications, adherence to antihypertensive treatment, previous hypertension with oral contraceptives or pregnancy.
- **Risk factors:** Personal history of CVD (myocardial infarction, heart failure [HF], stroke, transient ischemic attacks [TIA], diabetes, dyslipidemia, chronic kidney disease [CKD], smoking status, diet, alcohol intake, physical activity, psychosocial aspects, history of depression). Family history of hypertension, premature CVD, (familial) hypercholesterolemia, diabetes.
- **Assessment of overall cardiovascular risk:** In line with local guidelines/recommendations (see risk scores in Section 11 at the end of the document).
- **Symptoms/signs of hypertension/coexistent illnesses:** Chest pain, shortness of breath, palpitations, claudication, peripheral edema, headaches, blurred vision, nocturia, hematuria, dizziness.
- **Symptoms suggestive of secondary hypertension:** Muscle weakness/tetany, cramps, arrhythmias (hypokalemia/primary aldosteronism), flash pulmonary edema (renal artery stenosis), sweating, palpitations, frequent headaches (pheochromocytoma), snoring, daytime sleepiness (obstructive sleep apnea), symptoms suggestive of thyroid disease (see Section 10 for full list of symptoms).

Physical Examination

A thorough physical examination can assist with confirming the diagnosis of hypertension and the identification of HMOD and/or secondary hypertension and should include:

- **Circulation and heart:** Pulse rate/rhythm/character, jugular venous pulse/pressure, apex beat, extra heart sounds, basal crackles, peripheral edema, bruits (carotid, abdominal, femoral), radio-femoral delay.
- **Other organs/systems:** Enlarged kidneys, neck circumference >40 cm (obstructive sleep apnea), enlarged thyroid, increased body mass index (BMI)/waist circumference, fatty deposits and coloured striae (Cushing disease/syndrome).

Laboratory Investigations and ECG

- **Blood tests:** Sodium, potassium, serum creatinine and estimated glomerular filtration rate (eGFR). If available, lipid profile and fasting glucose.
- **Urine test:** Dipstick urine test.
- **12-lead ECG:** Detection of atrial fibrillation, left ventricular hypertrophy (LVH), ischemic heart disease.

OPTIMAL

Additional Diagnostic Tests

Additional investigations when indicated can be undertaken to assess and confirm suspicion of HMOD, coexistent diseases or/and secondary hypertension.

Imaging Techniques

- **Echocardiography:** LVH, systolic/diastolic dysfunction, atrial dilation, aortic coarctation.
- **Carotid ultrasound:** Plaques (atherosclerosis), stenosis.
- **Kidneys/renal artery and adrenal imaging:** Ultrasound/renal artery Duplex; CT-/MR-angiography: renal parenchymal disease, renal artery stenosis, adrenal lesions, other abdominal pathology.
- **Fundoscopy:** Retinal changes, hemorrhages, papilledema, tortuosity, nipping.
- **Brain CT/MRI:** Ischemic or hemorrhagic brain injury due to hypertension.

Functional Tests and Additional Laboratory Investigations

- **Ankle-brachial index:** Peripheral (lower extremity) artery disease.
- **Further testing for secondary hypertension if suspected:** Aldosterone-renin ratio, plasma free metanephrines, late-night salivary cortisol or other screening tests for cortisol excess.
- Urinary albumin/creatinine ratio
- Serum uric acid (s-UA) levels
- Liver function tests

Section 5: Cardiovascular Risk Factors

Diagnostic Approach

- More than 50% of hypertensive patients have additional cardiovascular risk factors.[28,29]
- The most common additional risk factors are diabetes (15%–20%), lipid disorders (elevated low-density lipoprotein-cholesterol [LDL-C] and triglycerides [30%]), overweight-obesity (40%), hyperuricemia (25%) and metabolic syndrome (40%), as well as unhealthy lifestyle habits (eg, smoking, high alcohol intake, sedentary lifestyle).[28–30]
- The presence of one or more additional cardiovascular risk factors proportionally increases the risk of coronary, cerebrovascular, and renal diseases in hypertensive patients.[1]

ESSENTIAL

- An evaluation of additional risk factors should be part of the diagnostic workup in hypertensive patients particularly in the presence of a family history of CVD.
- Cardiovascular risk should be assessed in all hypertensive patients by easy-to-use scores based on BP levels and additional risk factors according to a simplified version of the approach proposed by ESC-ESH Guidelines (Table 6).[1]
- A reliable estimate of cardiovascular risk can be obtained in daily practice by including:
- **Other Risk Factors**: Age (>65 years), sex (male>female), heart rate (>80 beats/min), increased body weight, diabetes, high LDL-C/triglyceride, family history of CVD, family history of hypertension, early-onset menopause, smoking habits, psychosocial or socioeconomic factors. **HMOD:** LVH (LVH with ECG), moderate-severe CKD (CKD; eGFR <60 ml/min/1.73m^2), any other available measure of organ damage. **Disease:** previous coronary heart disease (CHD), HF, stroke, peripheral vascular disease, atrial fibrillation, CKD stage 3+.

Table 6. Simplified Classification of Hypertension Risk according to additional Risk Factors, Hypertension-Mediated Organ Damage (HMOD), and Previous Disease*

Other Risk Factors, HMOD, or Disease	High-Normal SBP 130–139 DBP 85–89	Grade 1 SBP 140–159 DBP 90–99	Grade 2 SBP ≥160 DBP ≥100
No other risk factors	Low	Low	Moderate / High
1 or 2 risk factors	Low	Moderate	High
≥3 risk factors	Low / Moderate	High	High
HMOD, CKD grade 3, diabetes mellitus, CVD	High	High	High

*Example based on a 60 year old male patient. Categories of risk will vary according to age and sex.

- The therapeutic strategy must include lifestyle changes, BP control to target and the effective treatment of the other risk factors to reduce the residual cardiovascular risk.
- The combined treatment of hypertension and additional cardiovascular risk factors reduces the rate of CVD beyond BP control.

Other Additional Risk Factors

- Elevated serum uric acid (s-UA) is common in patients with hypertension and should be treated with diet, urate influencing drugs (losartan, fibrates, atorvastatin) or urate lowering drugs in symptomatic patients (gout with s-UA >6 mg/dl [0.357 mmol/L]).
- An increase in cardiovascular risk must be considered in patients with hypertension and chronic inflammatory diseases, chronic obstructive pulmonary disease (COPD), psychiatric disorders, psychosocial stressors where an effective BP control is warranted.[1]

Section 6: Hypertension-Mediated Organ Damage (HMOD)

Definition and Role of HMOD in Hypertension Management

Hypertension-mediated organ damage (HMOD) is defined as the structural or functional alteration of the arterial vasculature and/or the organs it supplies that is caused by elevated BP. End organs include the brain, the heart, the kidneys, central and peripheral arteries, and the eyes.

While assessment of overall cardiovascular risk is important for the management of hypertension, additional detection of HMOD is unlikely to change the management of those patients already identified as high risk (ie, those with established CVD, stroke, diabetes, CKD, or familial hypercholesterolemia). However, it can provide important therapeutic guidance on (1) management for hypertensive patients with low or moderate overall risk through reclassification due to presence of HMOD, and (2) preferential selection of drug treatment based on the specific impact on HMOD.[1]

Specific Aspects of HMOD and Assessment

- **Brain:** TIA or strokes are common manifestations of elevated BP. Early subclinical changes can be detected most sensitively by magnetic resonance imaging (MRI) and include white matter lesions, silent microinfarcts, microbleeds, and brain atrophy. Due to costs and limited availability brain MRI is not recommended for routine practice but should be considered in patients with neurologic disturbances, cognitive decline and memory loss.
- **Heart:** A 12-lead ECG is recommended for routine workup of patients with hypertension and simple criteria (Sokolow-Lyon index: SV1+RV5 ≥35 mm, Cornell index: SV3+RaVL >28 mm for men or >20 mm for women and Cornell voltage duration product: >2440 mm•ms) are available to detect presence of LVH. Sensitivity of ECG-LVH is very limited and a two-dimensional transthoracic echocardiogram (TTE) is the method of choice to accurately assess LVH (left ventricular mass index [LVMI]: men >115 g/m^2; women >95 g/m^2) and relevant parameters including LV geometry, left atrial volume, LV systolic and diastolic function and others.
- **Kidneys:** Kidney damage can be a cause and consequence of hypertension and is best assessed routinely by simple renal function parameters (serum creatinine and eGFR) together with investigation for albuminuria (dipstick or urinary albumin creatinine ratio [UACR]) in early morning spot urine).
- **Arteries:** Three vascular beds are commonly assessed to detect arterial HMOD: (1) the carotid arteries through carotid ultrasound to detect atherosclerotic plaque burden/stenosis and intima media thickness (IMT); (2) the aorta by carotid-femoral pulse wave velocity (PWV) assessment to detect large artery stiffening; and (3) the lower extremity arteries by assessment of the ankle-brachial index (ABI). Although there is evidence to indicate that all three provide added value beyond traditional risk factors, their routine use is currently not recommended unless clinically indicated, that is, in patients with neurologic symptoms, isolated systolic hypertension, or suspected peripheral artery disease, respectively.
- **Eyes:** Fundoscopy is a simple clinical bedside test to screen for hypertensive retinopathy although interobserver and intraobserver reproducibility is limited. Fundoscopy is particularly important in hypertensive urgencies and emergencies to detect retinal hemorrhage, microaneurysms, and papilledema in patients with accelerated or malignant hypertension. Fundoscopy should be performed in patients with grade 2 hypertension, ideally by experienced examiners or alternative techniques to visualize the fundus (digital fundus cameras) where available.

ESSENTIAL

The following assessments to detect HMOD should be performed routinely in all patients with hypertension:

- Serum creatinine and eGFR
- Dipstick urine test
- 12-lead ECG

OPTIMAL

All other techniques mentioned above can add value to optimize management of hypertension in affected individuals

Table 7. Drug/Substance Exacerbators and Inducers of Hypertension

Drug/Substance[32-43]	Comments on Specific Drugs and Substances*
Nonsteroidal anti-inflammatory drugs (NSAIDs)	No difference or an increase of up to 3/1 mm Hg with celecoxib 3/1 mm Hg increase with nonselective NSAIDs No increase in blood pressure with aspirin NSAIDs can antagonize the effects of RAAS-inhibitors and beta blockers
Combined oral contraceptive pill	6/3 mm Hg increase with high doses of estrogen (>50 mcg of estrogen and 1–4 mcg progestin)
Antidepressants	2/1 mm Hg increase with SNRI (selective norepinephrine and serotonin reuptake inhibitors) Increased odds ratio of 3.19 of hypertension with tricyclic antidepressant use No increases in blood pressure with SSRI (selective serotonin reuptake inhibitors)
Acetaminophen	Increased relative risk of 1.34 of hypertension with almost daily acetaminophen use
Other medications	Steroids Antiretroviral therapy: inconsistent study findings for increased blood pressure Sympathomimetics: pseudoephedrine, cocaine, amphetamines Antimigraine serotonergics Recombinant human erythropoeitin Calcineurin inhibitors Antiangiogenesis and kinase inhibitors 11 ß-hydroxysteroid dehydrogenase type 2 inhibitors
Herbal and other substances[44-45]	Alcohol, ma-huang, ginseng at high doses, liquorice, St. John's wort, yohimbine

*Average increase in blood pressure or risk of hypertension. However, the effect of these medications/ substances on blood pressure may highly vary between individuals.

and should be considered where clinically indicated and available. Serial assessment of HMOD (LVH and albuminuria) to monitor regression with antihypertensive treatment may be helpful to determine the efficacy of treatment in individual patients but this has not been sufficiently validated for most measures of HMOD.

Section 7: Exacerbators and Inducers of Hypertension

Background

Several medications and substances may increase BP or antagonize the BP-lowering effects of antihypertensive therapy in individuals (Table 7). It is important to note that the individual effect of these substances on BP can be highly variable with greater increases noted in the elderly, those with higher baseline BP, using antihypertensive therapy or with kidney disease.

ESSENTIAL OPTIMAL

- Screen all patients (with hypertension and those at risk for hypertension) for substances that may increase BP or interfere with the BP-lowering effect of antihypertensive medications.
- Where appropriate, consider reducing or eliminating substances that raise BP. If these substances are required or preferred, then treat BP to target regardless. (See resource[31] on possible antihypertensive therapies that target mechanisms underlying the raised BP induced by these substances).

Section 8: Treatment of Hypertension

8.1 Lifestyle Modifications

Healthy lifestyle choices can prevent or delay the onset of high BP and can reduce cardiovascular risk.[46] Lifestyle modification is also the first line of antihypertensive treatment. Modifications in lifestyle can also enhance the effects of antihypertensive treatment. Lifestyle modifications should include the following (Table 8).[47–64]

Seasonal BP Variation[65]

BP exhibits seasonal variation with lower levels at higher temperatures and higher at lower temperatures. Similar changes occur in people traveling from places with cold to hot temperature, or the reverse. A meta-analysis showed average BP decline in summer of 5/3 mm Hg (systolic/diastolic). BP changes are larger in treated hypertensives and should be considered when symptoms suggesting over-treatment appear with temperature rise, or BP is increased during cold weather. BP below the recommended goal should be considered for possible downtitration, particularly if there are symptoms suggesting overtreatment.

8.2 Pharmacological Treatment

Contemporary data from over 100 countries[66,67] suggest that on average, less than 50% of adults with hypertension receive BP-lowering medication, with few countries performing better than this and many worse. This is despite the fact that a difference in BP of 20/10 mm Hg is associated with a 50% difference in cardiovascular risk.[68]

The pharmacological treatment strategies recommended here (Figures 2–4) are largely compatible with those made in the most recent US[2] and European guidelines.[1,8]

8.3 Adherence to Antihypertensive Treatment

Background

Adherence is defined as to the extent to which a person's behaviors such as taking a medication, following a diet or executing lifestyle changes corresponds with agreed recommendations from a healthcare provider.[74] Nonadherence to antihypertensive treatment affects 10%–80% of hypertensive patients and is one of the key drivers of suboptimal BP control.[75–77] Poor adherence to antihypertensive treatment correlates with the magnitude of BP elevation and is an indicator of poor prognosis in hypertensive patients.[78–81] The etiology of nonadherence to antihypertensive treatment is multifactorial and includes causes associated with the healthcare system, pharmacological therapy, the disease, patients and their socioeconomic status.[74]

Table 8. Lifestyle Modifications

Salt reduction	There is strong evidence for a relationship between high salt intake and increased blood pressure.[47] Reduce salt added when preparing foods, and at the table. Avoid or limit consumption of high salt foods such as soy sauce, fast foods and processed food including breads and cereals high in salt.
Healthy diet	Eating a diet that is rich in whole grains, fruits, vegetables, polyunsaturated fats and dairy products and reducing food high in sugar, saturated fat and trans fats, such as the DASH diet (http://www.dashforhealth.com).[48] Increase intake of vegetables high in nitrates known to reduce BP, such as leafy vegetables and beetroot. Other beneficial foods and nutrients include those high in magnesium, calcium and potassium such as avocados, nuts, seeds, legumes and tofu.[49]
Healthy drinks	Moderate consumption of coffee, green and black tea.[50] Other beverages that can be beneficial include karkadé (hibiscus) tea, pomegranate juice, beetroot juice and cocoa.[49]
Moderation of alcohol consumption	Positive linear association exists between alcohol consumption, blood pressure, the prevalence of hypertension, and CVD risk.[51] The recommended daily limit for alcohol consumptions is 2 standard drinks for men and 1.5 for women (10 g alcohol/standard drink). Avoid binge drinking.
Weight reduction	Body weight control is indicated to avoid obesity. Particularly abdominal obesity should be managed. Ethnic-specific cut-offs for BMI and waist circumference should be used.[52] Alternatively, a waist-to-height ratio <0.5 is recommended for all populations.[53,54]
Smoking cessation	Smoking is a major risk factor for CVD, COPD and cancer. Smoking cessation and referral to smoking cessation programs are advised.[55]
Regular physical activity	Studies suggest that regular aerobic and resistance exercise may be beneficial for both the prevention and treatment of hypertension.[56–58] Moderate intensity aerobic exercise (walking, jogging, cycling, yoga, or swimming) for 30 minutes on 5–7 days per week or HIIT (high intensity interval training) which involves alternating short bursts of intense activity with subsequent recovery periods of lighter activity. Strength training also can help reduce blood pressure. Performance of resistance/strength exercises on 2–3 days per week.
Reduce stress and induce mindfulness	Chronic stress has been associated to high blood pressure later in life.[59] Although more research is needed to determine the effects of chronic stress on blood pressure, randomized clinical trials examining the effects of transcendental meditation/mindfulness on blood pressure suggest that this practice lowers blood pressure.[60] Stress should be reduced and mindfulness or meditation introduced into the daily routine.
Complementary, alternative or traditional medicines	Large proportions of hypertensive patients use complementary, alternative or traditional medicines (in regions such as Africa and China)[61,62] yet large-scale and appropriate clinical trials are required to evaluate the efficacy and safety of these medicines. Thus, use of such treatment is not yet supported.
Reduce exposure to air pollution and cold temperature	Evidence from studies support a negative effect of air pollution on blood pressure in the long-term.[63,64]

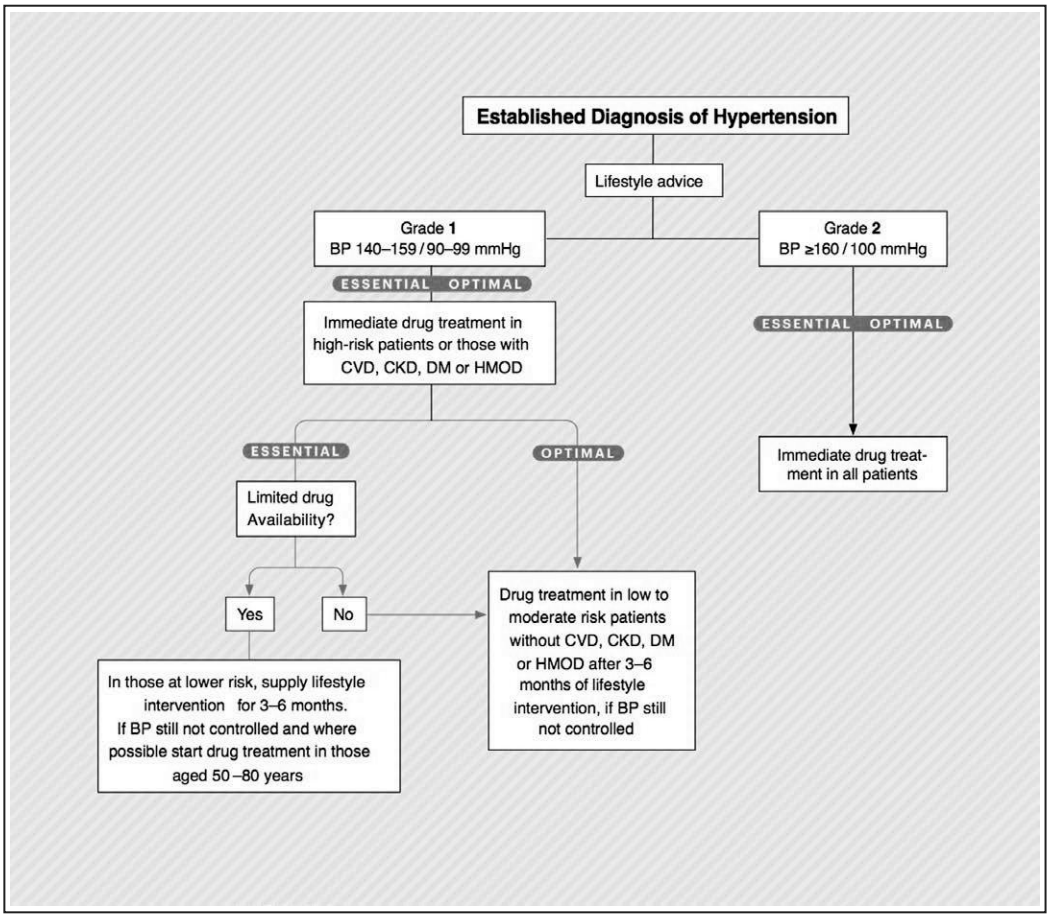

Figure 2. Pharmacological treatment of hypertension: general scheme. See Table 2 (Section 2) for equivalent BP levels based on ambulatory or home BP recordings.

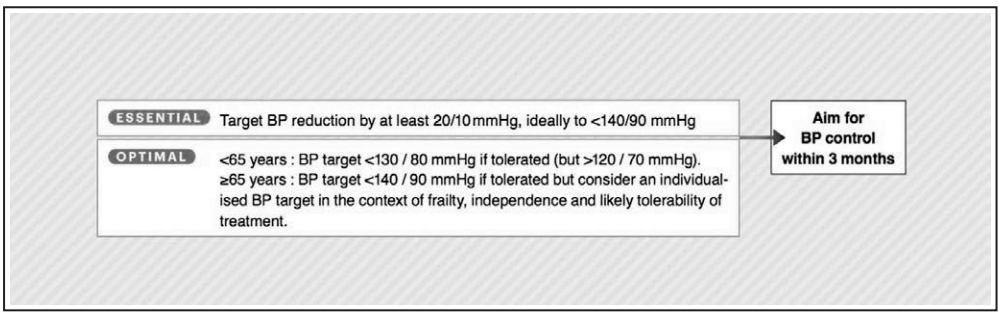

Figure 3. Office blood pressure targets for treated hypertension.

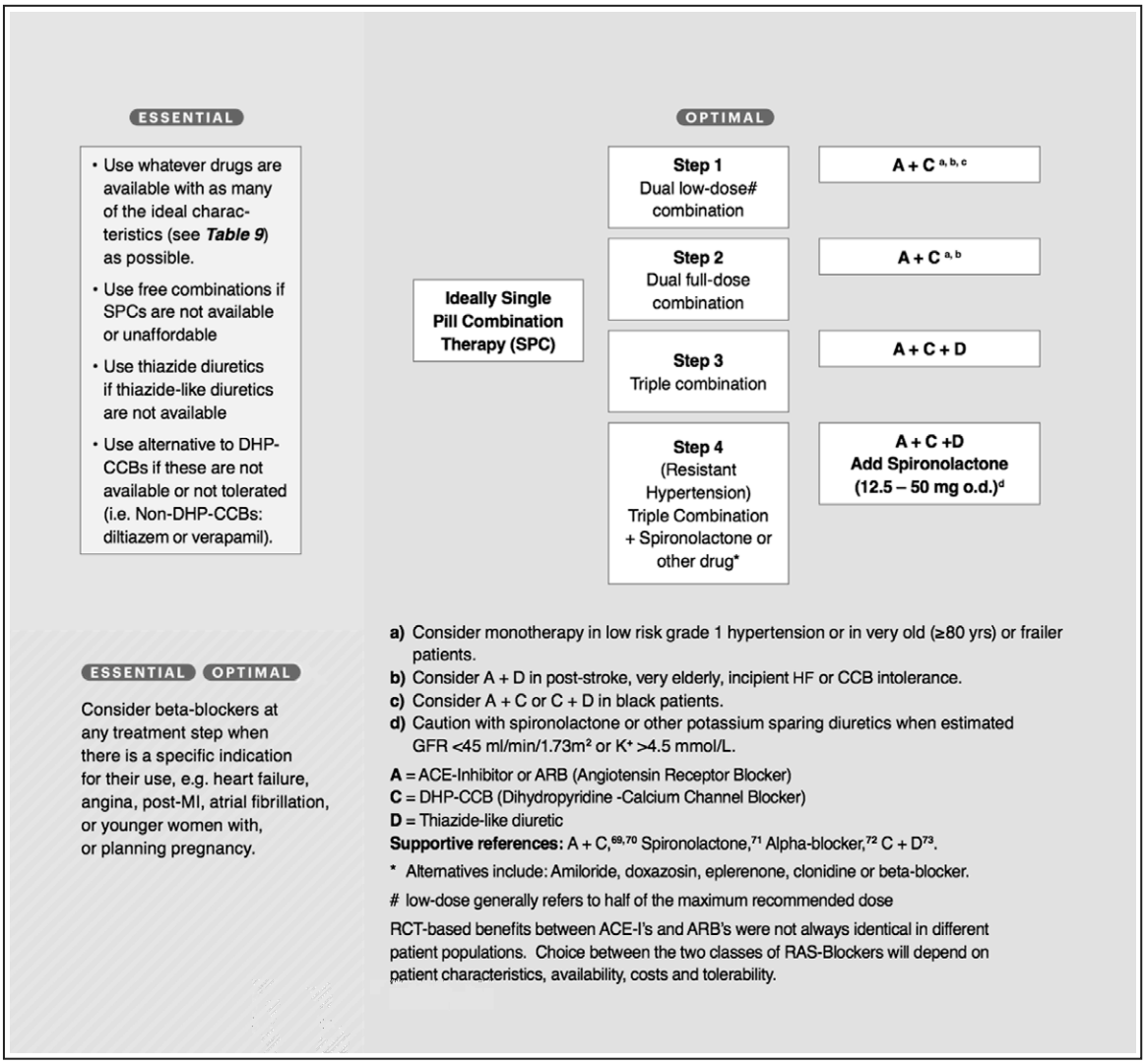

Figure 4. ISH core drug-treatment strategy. Data from references 69–73. Ideal characteristics of drug treatment (see Table 9).

Table 9. Ideal Characteristics of Drug Treatment

1.	Treatments should be evidence-based in relation to morbidity/mortality prevention.
2.	Use a once-daily regimen which provides 24-hour blood pressure control.
3.	Treatment should be affordable and/or cost-effective relative to other agents.
4.	Treatments should be well-tolerated.
5.	Evidence of benefits of use of the medication in populations to which it is to be applied.

Recommendations: Adherence to Antihypertensive Therapy

ESSENTIAL OPTIMAL

- Evaluate adherence to antihypertensive treatment as appropriate at each visit and prior to escalation of antihypertensive treatment.
- Consider the following strategies to improve medication adherence[82-87]
  a. reducing polypharmacy – use of single pill combinations
  b. once-daily dosing over multiple times per day dosing
  c. linking adherence behavior with daily habits
  d. providing adherence feedback to patients
  e. home BP monitoring
  f. reminder packaging of medications
  g. empowerment-based counseling for self-management
  h. electronic adherence aids such as mobile phones or short messages services
  i. multidisciplinary healthcare team approach (ie, pharmacists) to improve monitoring for adherence

OPTIMAL

- Objective indirect (ie, review of pharmacy records, pill counting, electronic monitoring devices) and direct (ie, witnessed intake of medications, biochemical detection of medications in urine or blood) are generally preferred over subjective methods to diagnose nonadherence to antihypertensive treatment.[80,85]
- The most effective methods for management of nonadherence require complex interventions that combine counseling, self-monitoring, reinforcements and supervision.

Section 9: Common and Other Comorbidities and Complications of Hypertension

Background

- Hypertensive patients have several common and other comorbidities that can affect cardiovascular risk and treatment strategies.
- The number of comorbidities increases with age, with the prevalence of hypertension and other diseases.
- Common comorbidities include coronary artery disease (CAD), stroke, CKD, HF, and COPD.
- Uncommon comorbidities include rheumatic diseases and psychiatric diseases.
- Uncommon comorbidities are largely underestimated by guidelines and frequently treated with drugs often self-prescribed and possibly interfering with BP control.
- Common and uncommon comorbidities should be identified and managed according to available evidence.

Common Comorbidities and Complications

Hypertension and Coronary Artery Disease (CAD)

- A strong epidemiological interaction exists between CAD and hypertension that accounts for 25%–30% of acute myocardial infarctions.[88]
- Lifestyle changes are recommended (smoking cessation, diet and exercise).
- BP should be lowered if ≥140/90 mm Hg and treated to a target <130/80 mm Hg (<140/80 in elderly patients).
- RAS blockers, beta-blockers irrespective of BP levels with or without calcium channel blockers (CCBs) are first-line drugs in hypertensive patients.[1]
- Lipid-lowering treatment with an LDL-C target <55 mg/dL (1.4 mmol/L).[89]
- Antiplatelet treatment with acetyl salicylic acid is routinely recommended.[1]

Hypertension and Previous Stroke

- Hypertension is the most important risk factor for ischemic or hemorrhagic stroke.[90]
- Stroke can be largely prevented by BP control.
- BP should be lowered if ≥140/90 mm Hg and treated to a target <130/80 mm Hg (<140/80 in elderly patients).[1]
- RAS blockers, CCBs, and diuretics are first-line drugs.[1]
- Lipid-lowering treatment is mandatory with a LDL-C target <70 mg/dL (1.8 mmol/L) in ischemic stroke.[1]
- Antiplatelet treatment is routinely recommended for ischemic stroke, but not hemorrhagic stroke, and should be carefully considered in patients with hemorrhagic stroke only in the presence of a strong indication.[1]

Hypertension and Heart Failure (HF)

- Hypertension is a risk factor for the development of HF with reduced ejection fraction (HFrEF), and with preserved ejection fraction (HFpEF). Clinical outcome is worse and mortality is increased in hypertensive patients with HF.[2]
- Lifestyle changes are recommended (diet and exercise).
- Treating hypertension has a major impact on reducing the risk of incident HF and HF hospitalization. BP should be lowered if ≥140/90 mm Hg and treated to a target <130/80 mm Hg but >120/70 mm Hg.
- RAS blockers, beta-blockers, and mineralocorticoid receptor antagonists are all effective in improving clinical outcome in patients with established HFrEF, whereas for diuretics, evidence is limited to symptomatic improvement.[1] CCBs are indicated on in case of poor BP control.
- Angiotensin receptor-neprilysin inhibitor (ARNI; sacubitril-valsartan) is indicated for the treatment of HFrEF as an alternative to ACE inhibitors or ARBs also in hypertensive populations. The same treatment strategy can be applied to patients with HFpEF even if the optimal treatment strategy is not known.[91]

Hypertension and Chronic Kidney Disease (CKD)

- Hypertension is a major risk factor for the development and progression of albuminuria and any form of CKD.[92]
- A lower eGFR is associated with resistant hypertension, masked hypertension, and elevated nighttime BP values.[92]
- The effects of BP lowering on renal function (and albuminuria) are dissociated from cardiovascular benefit.[1]
- BP should be lowered if ≥140/90 mm Hg and treated to a target <130/80 mm Hg (<140/80 in elderly patients).[1]
- RAS-inhibitors are first-line drugs because they reduce albuminuria in addition to BP control. CCBs and diuretics (loop-diuretics if eGFR <30 ml/min/1.73m^2) can be added.[1]
- eGFR, microalbuminuria and blood electrolytes should be monitored.[1]

Hypertension and Chronic Obstructive Pulmonary Disease (COPD)

- Hypertension is the most frequent comorbidity in patients with COPD.

- BP should be lowered if ≥140/90 mm Hg and treated to a target <130/80 mm Hg (<140/80 in elderly patients).
- Lifestyle changes (smoking cessation) are mandatory.[93]
- Environmental (air) pollution should be considered and avoided if possible.[93]
- The treatment strategy should include an angiotensin AT_1-receptor blocker (ARB) and CCB and/or diuretic, while beta blockers ($ß_1$-receptor selective) may be used in selected patients (eg, CAD, HF).
- Additional cardiovascular risk factors should be managed according to cardiovascular risk profile.

HIV/AIDS

- People living with HIV are at increased cardiovascular risk.[40]
- There may be a drug interaction with CCB under most of the antiretroviral therapies.
- Hypertension management should be similar to the general hypertensive populations.

Management of Comorbidities

ESSENTIAL OPTIMAL

- In addition to BP control, the therapeutic strategy should include lifestyle changes, body weight control and the effective treatment of the other risk factors to reduce the residual cardiovascular risk.[1]
- Lifestyle changes as in Table 8.
- LDL-cholesterol should be reduced according to risk profile: (1) >50% and <70 mg/dL (1.8 mmol/L) in hypertension and CVD, CKD, DM or no CVD and high risk; (2) >50% and <100 mg/dL (2.6 mmol/L) in high-risk patients; (3) <115 mg/dL (3 mmol/L) in moderate-risk patients.[1,89]
- Fasting serum glucose levels should be reduced below 126 mg/dL (7 mmol/L) or HbA1c below 7% (53 mmol/mol).[1]
- s-UA should be maintained below 6.5 mg/dL (0.387 mmol/L), and <6 mg/dL (0.357 mmol/L) in patients with gout.[94]
- Antiplatelet therapy should be considered in patients with CVD (secondary prevention only).[95]

Diabetes

- BP should be lowered if ≥140/90 mm Hg and treated to a target <130/80 mm Hg (<140/80 in elderly patients).[96]
- The treatment strategy should include an RAS inhibitor (and a CCB and/or thiazide-like diuretic).
- The treatment should include a statin in primary prevention if LDL-C >70 mg/dL (1.8 mmol/L) (diabetes with target organ damage) or >100 mg/dL (2.6 mmol/L) (uncomplicated diabetes).
- The treatment should include glucose and lipid lowering as per current guidelines (see Section 11: Resources).

Lipid Disorders

- BP should be lowered as done in the general population, preferentially with RAS-inhibitors (ARB, ACE-I) and CCBs.[97]
- Statins are the lipid-lowering treatment of choice with or without ezetimibe and/or PCSK9 inhibitor (in the optimal setting).[98]
- Serum triglyceride lowering should be considered if >200 mg/dL (2.3 mmol/L) particularly in patients with hypertension and DM. Possible additional benefits using fenofibrate in low HDL/high triglyceride subgroup.

Metabolic Syndrome (MS)

- Patients with hypertension and MS have a high-risk profile.
- The diagnosis of MS should be made by separate evaluation of single components.
- The treatment of MS is based on changes in lifestyle (diet and exercise).
- The treatment of hypertension and MS should include BP control as in the general population and treatment of additional risk factors based on level and overall cardiovascular risk (SCORE and/or ASCVD calculator).

Other Comorbidities

(See Table 10).

Hypertension and Inflammatory Rheumatic Diseases (IRD)

- IRD (rheumatoid arthritis, psoriasis-arthritis, etc) are associated with an increased prevalence of hypertension under diagnosed and poorly controlled.[99,100]
- IRD show an increase in cardiovascular risk only partially related to cardiovascular risk factors.[99]
- Rheumatoid arthritis is predominant among IRD.
- The presence of IRD should increase 1 step of cardiovascular risk.[99]
- BP should be lowered as in the general population, preferentially with RAS-inhibitors (evidence of an overactive RAAS)[100] and CCBs.
- Underlying diseases should be effectively treated by reducing inflammation and by avoiding high doses of NSAIDs.
- Lipid-lowering drugs should be used according to cardiovascular risk profile (SCORE/ASCVD calculator) also considering the effects of biologic drugs.[100]

Hypertension and Psychiatric Diseases

- The prevalence of hypertension is increased in patients with psychiatric disorders and in particular depression.[101,102]
- According to guidelines, psychosocial stress and major psychiatric disorders increase the cardiovascular risk.
- Depression has been associated with cardiovascular morbidity and mortality, suggesting the importance of BP control.[101]
- BP should be lowered as in the general population, preferentially with RAS-inhibitors and diuretics with a lesser rate of pharmacological interactions under antidepressants. CCBs and $alpha_1$-blockers should be used with care in patients with orthostatic hypotension (eg, SRIs).
- The risk of pharmacologic interactions, ECG abnormalities and postural BP changes must be considered.
- Beta-blockers (not metoprolol) should be used in presence of drug-induced tachycardia (antidepressant, antipsychotic drugs).[103]
- Additional risk factors should be managed according to cardiovascular risk profile (SCORE/ASCVD calculator, see Section 11: Resources).

Table 10. Outline of Evidence-Based Management of Other Comorbidities and Hypertension

Additional Comorbidity	Recommended Drugs	Warning
Rheumatic disorders	• RAS-inhibitors and CCBs±diuretics • Biologic drugs not affecting blood pressure should be preferred (where available)	High doses of NSAIDs
Psychiatric disorders	• RAS-inhibitors and diuretics • Beta-blockers (not metoprolol) if drug-induced tachycardia (antidepressant, antipsychotic drugs). • Lipid-lowering drugs/ antidiabetic drugs according to risk profile	Avoid CCBs if orthostatic hypotension (SRIs)

Section 10: Specific Circumstances

10.1 Resistant Hypertension

Background

Resistant hypertension is defined as seated office BP >140/90 mm Hg in a patient treated with three or more antihypertensive medications at optimal (or maximally tolerated) doses including a diuretic and after excluding pseudoresistance (poor BP measurement technique, white coat effect, nonadherence and suboptimal choices in antihypertensive therapy)[104,105] as well as the substance/drug-induced hypertension and secondary hypertension.[79] Resistant hypertension affects around 10% of hypertensive individuals, has a negative impact on well-being[106] and increases the risk of coronary artery disease, chronic HF, stroke, end-stage renal disease, and all-cause mortality.[107] Approximately 50% of patients diagnosed with resistant hypertension have pseudoresistance rather than true resistant hypertension.[104,105,108]

Recommendations

ESSENTIAL

- If seated office BP >140/90 mm Hg in patients managed with three or more antihypertensive medications at optimal (or maximally tolerated) doses including a diuretic, first exclude causes of pseudoresistance (poor BP measurement technique, white coat effect, nonadherence and suboptimal choices in antihypertensive therapy), and substance-induced increases in BP.
- Consider screening patients for secondary causes as appropriate (refer to Section 10.2).
- Optimize the current treatment regimen including health behavior change and diuretic-based treatment (maximally tolerated doses of diuretics, and optimal choice of diuretic: use of thiazide-like rather than thiazide diuretics, and initiation of loop diuretics for eGFR <30 ml/min/1.73m^2 or clinical volume overload).[109]
- Add a low dose of spironolactone as the 4th line agent in those whose serum potassium is <4.5 mmol/L and whose eGFR is >45 ml/min/1.73m^2 to achieve BP targets.[8,71,110] If spironolactone is contraindicated or not tolerated, amiloride, doxazosin, eplerenone, clonidine, and beta-blockers are alternatives, or any available antihypertensive class not already in use.[1,111–114]

OPTIMAL

- Resistant hypertension should be managed in specialist centers with sufficient expertize, and resources necessary to diagnose and treat this condition.[115]

10.2 Secondary Hypertension[116-121]

Background

A specific cause of secondary hypertension can be identified in 5%–10% of hypertensive patients (Table 11). Early diagnosis of secondary hypertension and the institution of appropriate targeted treatment have the potential to cure hypertension in some patients or improve BP control/reduce the number of prescribed antihypertensive medications in others. The most common types of secondary hypertension in adults are renal parenchymal disease, renovascular hypertension, primary aldosteronism, chronic sleep apnea, and substance/drug-induced.

Recommendations

ESSENTIAL

- Consider screening for secondary hypertension in (1) patients with early onset hypertension (<30 years of age) in particular in the absence of hypertension risk factors (obesity, metabolic syndrome, familial history etc.), (2) those with resistant hypertension, (3) individuals with sudden deterioration in BP control, (4) hypertensive urgency and emergency, (5) those presenting with high probability of secondary hypertension based on strong clinical clues.
- In patients with resistant hypertension, investigations for secondary hypertension should generally be preceded by exclusion of pseudoresistant hypertension and drug/substance-induced hypertension.
- Basic screening for secondary hypertension should include a thorough assessment of history, physical examination (see clinical clues), basic blood biochemistry (including serum sodium, potassium, eGFR, TSH), and dipstick urine analysis.

OPTIMAL

- Further investigations for secondary hypertension (additional biochemistry/imaging/others) should be carefully chosen based on information from history, physical examination and basic clinical investigations.
- Consider referring for further investigation and management of suspected secondary hypertension to a specialist center with access to appropriate expertize and resources.

10.3 Hypertension in Pregnancy[122-126]

Hypertension in pregnancy is a condition affecting 5%–10% of pregnancies worldwide. Maternal risks include placental abruption, stroke, multiple organ failure (liver, kidney), disseminated vascular coagulation. Fetal risks include intrauterine growth retardation, preterm birth, intrauterine death. Hypertension in pregnancy includes the following conditions:

- **Preexisting hypertension:** Starts before pregnancy or <20 weeks of gestation, and lasts >6 weeks postpartum with proteinuria.

Table 11. Features of Secondary Hypertension

Secondary Hypertension	Clinical History and Physical Examination	Basic Biochemistry and Urine Analysis	Further Diagnostic Tests
Renal parenchymal disease	• Personal/familial history of CKD	• Proteinuria, hematuria, leukocyturia on dipstick urine analysis • Decreased estimated GFR	• Kidney ultrasound
Primary aldosteronism	• Symptoms of hypokalemia (muscle weakness, muscle cramps, tetany)	• Spontaneous hypokalemia or diuretic-induced hypokalemia on blood biochemistry (50%–60% of patients are normokalemic). • Elevated plasma aldosterone-renin activity ratio	• Confirmatory testing (eg, intravenous saline suppression test) • Imaging of adrenals (adrenal computed tomography) • Adrenal vein sampling
Renal artery stenosis	• Abdominal bruit • Bruits over other arteries (ie, carotid and femoral arteries) • Drop in estimated GFR >30% after exposure to ACE-inhibitors/ARBs • For suspected atherosclerotic RAS, history of flash pulmonary edema or history of atherosclerotic disease or presence of cardiovascular risk factors • For suspected fibromuscular dysplasia, young women with onset of hypertension <30 years	• Decrease in estimated GFR	• Imaging of renal arteries (duplex ultrasound, abdominal computed tomography or magnetic resonance angiograms depending on availability and patient's level of renal function)
Pheochromocytoma	• Headaches • Palpitations • Perspiration • Pallor • History of labile hypertension	• Increased plasma levels of metanephrines • Increased 24-hour urinary fractional excretion of metanephrines and catecholamines	• Abdominal/pelvic computational tomography or MRI
Cushing's syndrome and disease	• Central obesity • Purple striae • Facial rubor • Signs of skin atrophy • Easy bruising • Dorsal and supraclavicular fat pad • Proximal muscle weakness	• Hypokalemia • Increased late-night salivary cortisol	• Dexamethasone suppression tests[118] • 24 hour urinary free cortisol • Abdominal/ pituitary imaging
Coarctation of the aorta	• Higher blood pressure in upper than lower extremities • Delayed or absent femoral pulses		• Echocardiogram • Computational tomography angiogram • Magnetic resonance angiogram
Obstructive sleep apnea	• Increased BMI • Snoring • Daytime sleepiness • Gasping or choking at night • Witnessed apneas during sleep • Nocturia		• Home sleep apnea testing (eg, level 3 sleep study) • Overnight polysomnography testing
Thyroid disease	• Symptoms of hyperthyroidism: heat intolerance, weight loss, tremor, palpitations • Symptoms of hypothyroidism: cold intolerance, weight gain, dry brittle hair	• TSH, Free T4	

- **Gestational hypertension:** Starts >20 weeks of gestation, and lasts <6 weeks postpartum.
- **Preexisting hypertension plus superimposed gestational hypertension** with proteinuria.
- **Preeclampsia:** Hypertension with proteinuria (>300 mg/24 h or ACR >30 mg/mmol [265 mg/g]). Predisposing factors are preexisting hypertension, hypertensive disease during previous pregnancy, diabetes, renal disease, first- or multiple pregnancy, autoimmune disease (SLE). Risks are fetal growth restriction, preterm birth.
- **Eclampsia:** Hypertension in pregnancy with seizures, severe headaches, visual disturbance, abdominal pain, nausea and vomiting, low urinary output: Immediate treatment and delivery required.
- **HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome:** Immediate treatment and delivery required.

Blood Pressure Measurement in Pregnancy

ESSENTIAL Office BP measurement following general guidelines. Take office BP measurement using a manual auscultatory device, or an automated upper-arm cuff device which has been validated specifically in pregnancy and preeclampsia (list of validated devices at www.stridebp.org).

OPTIMAL ABPM or home BP monitoring using devices validated specifically in pregnancy and preeclampsia to evaluate white coat hypertension, DM, nephropathy.

Investigation of Hypertension in Pregnancy

ESSENTIAL Urine analysis, full blood count, liver enzymes, hematocrit, serum creatinine and s-UA. Test for proteinuria in early pregnancy (preexisting renal disease) and second half of pregnancy (preeclampsia). A dipstick test >1+ should be followed up with UACR in a single spot urine; UACR <30 mg/mmol excludes proteinuria.

OPTIMAL Ultrasound of kidneys and adrenals, free plasma metanephrines (if clinical features of pheochromocytoma); Doppler ultrasound of uterine arteries (after 20 weeks of gestation is useful to detect those at higher risk of gestational hypertension, preeclampsia, and intrauterine growth retardation).

Prevention of Preeclampsia

Women at high risk (hypertension in previous pregnancy, CKD, autoimmune disease, diabetes, chronic hypertension), or moderate risk (first pregnancy in a woman >40 years, pregnancy interval >10 years, BMI >35 kg/m^2, family history of preeclampsia, multiple pregnancies): 75–162 mg aspirin at weeks 12–36. Oral calcium supplementation of 1.5–2 g/day is recommended in women with low dietary intake (<600 mg/day).

Management of Hypertension in Pregnancy

- **Mild hypertension:** Drug treatment at persistent BP >150/95 mm Hg in all women. Drug treatment at persistent BP >140/90 mm Hg in gestational hypertension, preexisting hypertension with superimposed gestational hypertension; hypertension with subclinical HMOD at any time during pregnancy. First choices: methyldopa, beta-blockers (labetalol), and dihydropyridine-calcium channel blockers (DHP-CCBs) (nifedipine [not capsular], nicardipine). Contraindicated: RAS blockers (ACE-I, ARB, direct renin inhibitors [DRI]) due to adverse fetal and neonatal outcomes.
- **Severe hypertension:** At BP >170 mm Hg systolic and/or >110 mm Hg diastolic: immediate hospitalization is indicated (emergency). Treatment with intravenous labetalol (alternative intravenous nicardipine, esmolol, hydralazine, urapidil), oral methyldopa or DHP-CCBs (nifedipine [not capsular] nicardipine). Add magnesium (hypertensive crisis to prevent eclampsia). In pulmonary edema: nitroglycerin intravenous infusion. Sodium-nitroprusside should be avoided due to the danger of fetal cyanide poisoning with prolonged treatment.
- **Delivery in gestational hypertension or preeclampsia:** At week 37 in asymptomatic women. Expedite delivery in women with visual disturbances, hemostatic disorders.
- **Blood pressure postpartum:** If hypertension persists, any of recommended drugs except methyldopa (postpartum depression).
- **Breastfeeding:** All antihypertensives excreted into breast milk at low concentrations. Avoid atenolol, propranolol, nifedipine (high concentration in milk). Prefer long acting CCBs. Refer to prescribing information.
- **Long-term consequences of gestational hypertension:** Increased risk of hypertension and CVD (stroke, ischemic heart disease) in later life.

ESSENTIAL Lifestyle adjustment

OPTIMAL Lifestyle adjustment and annual checkups (BP, metabolic factors)

10.4 Hypertensive Emergencies

Definition of Hypertensive Emergencies and Their Clinical Presentation

A hypertensive emergency is the association of substantially elevated BP with acute HMOD. Target organs include the retina, brain, heart, large arteries, and the kidneys.[127] This situation requires rapid diagnostic workup and immediate BP reduction to avoid progressive organ failure. Intravenous therapy is usually required. The choice of antihypertensive treatment is predominantly determined by the type of organ damage. Specific clinical presentations of hypertensive emergencies include:

- **Malignant hypertension:** Severe BP elevation (commonly >200/120 mm Hg) associated with advanced bilateral retinopathy (hemorrhages, cotton wool spots, papilledema).
- **Hypertensive encephalopathy:** Severe BP elevation associated with lethargy, seizures, cortical blindness and coma in the absence of other explanations.
- **Hypertensive thrombotic microangiopathy:** Severe BP elevation associated with hemolysis and thrombocytopenia in the absence of other causes and improvement with BP-lowering therapy.
- Other presentations of hypertensive emergencies include severe BP elevation associated with cerebral hemorrhage, acute stroke, acute coronary syndrome, cardiogenic pulmonary edema, aortic aneurysm/dissection, and severe preeclampsia and eclampsia.

Patients with substantially elevated BP who lack acute HMOD are not considered a hypertensive emergency and can typically be treated with oral antihypertensive therapy.[128]

Clinical Presentation and Diagnostic Workup

The clinical presentation of a hypertensive emergency can vary and is mainly determined by the organ(s) acutely affected. There is no specific BP threshold to define a hypertensive emergency.

Symptoms include headaches, visual disturbances, chest pain, dyspnea, neurologic symptoms, dizziness, and more unspecific presentations.

Medical history: preexisting hypertension, onset and duration of symptoms, potential causes (nonadherence with prescribed antihypertensive drugs, lifestyle changes, concomitant use of BP elevating drugs [NSAIDS, steroids, immunesuppressants, sympathomimetics, cocaine, antiangiogenic therapy]).

ESSENTIAL **Thorough physical examination:** Cardiovascular and neurologic assessment. Laboratory analysis: hemoglobin,

Table 12. Hypertensive Emergencies Requiring Immediate BP Lowering

Clinical Presentation	Timeline and Target BP	First Line Treatment	Alternative
Malignant hypertension with or without TMA or acute renal failure	Several hours, MAP –20% to –25%	Labetalol Nicardipine	Nitroprusside Urapidil
Hypertensive encephalopathy	Immediate, MAP –20% to –25%	Labetalol Nicardipine	Nitroprusside
Acute ischaemic stroke and SBP >220 mm Hg or DBP >120 mm Hg	1 h, MAP –15%	Labetalol Nicardipine	Nitroprusside
Acute ischaemic stroke with indication for thrombolytic therapy and SBP >185 mm Hg or DBP >110 mm Hg	1 h, MAP –15%	Labetalol Nicardipine	Nitroprusside
Acute hemorrhagic stroke and SBP >180 mm Hg	Immediate, 130<SBP<180 mm Hg	Labetalol Nicardipine	Urapidil
Acute coronary event	Immediate, SBP <140 mm Hg	Nitroglycerine Labetalol	Urapidil
Acute cardiogenic pulmonary edema	Immediate, SBP <140 mm Hg	Nitroprusside or nitroglycerine (with loop diuretic)	Urapidil (with loop diuretic)
Acute aortic disease	Immediate, SBP <120 mm Hg and heart rate <60 bpm	Esmolol and nitroprusside or nitroglycerine or nicardipine	Labetalol or metoprolol
Eclampsia and severe preeclampsia/ HELLP	Immediate, SBP <160 mm Hg and DBP <105 mm Hg	Labetalol or nicardipine and magnesium sulphate	

Adapted from van den Born et al.[127]

platelets, creatinine, sodium, potassium, lactate dehydrogenase (LDH), haptoglobin, urinalysis for protein, urine sediment. **Examinations:** Fundoscopy, ECG.

OPTIMAL Additional investigations may be required and indicated depending on presentation and clinical findings and may be essential in the context: troponins (chest pain), chest x-ray (congestion/fluid overload), transthoracic echocardiogram (cardiac structure and function), CT/MRI brain (cerebral hemorrhage/stroke), CT-angiography thorax/abdomen (acute aortic disease). Secondary causes can be found in 20%–40% of patients presenting with malignant hypertension[118] and appropriate diagnostic workup to confirm or exclude secondary forms is indicated.

Diagnostic Tests and Acute Therapeutic Management

The overall therapeutic goal in patients presenting with hypertensive emergencies is a controlled BP reduction to safer levels to prevent or limit further hypertensive damage while avoiding hypotension and related complications. There is a lack of randomized controlled trial data to provide clear cut guidance on BP targets and times within which these should be achieved. Most recommendations are based on expert consensus. The type of acute HMOD is the main determinant of the preferred treatment choice. The timeline and magnitude of BP reduction is strongly dependent on the clinical context. For example, acute pulmonary edema and aortic dissection require rapid BP reduction, whereas BP levels not exceeding 220/120 mm Hg are generally tolerated in acute ischemic stroke for certain periods. Table 12 provides a general overview of timelines and BP targets as well as preferred antihypertensive drug choices with most common clinical presentations. Availability of drugs and local experience with individual drugs are likely to influence the choice of drugs. Labetalol and nicardipine are generally safe to use in all hypertensive emergencies and should be available wherever hypertensive emergencies are being managed. Nitroglycerin and nitroprusside are specifically useful in hypertensive emergencies including the heart and the aorta.

Specific Situations

- **Sympathetic hyperreactivity:** If intoxication with amphetamines, sympathomimetics or cocain is suspected as cause of presentation with a hypertensive emergency use of benzodiazepines should be considered prior to specific antihypertensive treatment. Phentolamine, a competitive alpha-receptor blocking agent and clonidine, a centrally sympatholytic agent with additional sedative properties are useful if additional BP-lowering therapy is required. Nicardipine and nitroprusside are suitable alternatives.
- **Pheochromocytoma:** The adrenergic drive associated with pheochromocytoma responds well to phentolamine. Beta-blockers should only be used once alpha-blockers have been introduced to avoid acceleration of hypertension. Urapidil and nitroprusside are additional suitable options.
- **Preeclampsia/eclampsia:** See Section 10.3: Hypertension in Pregnancy.

Follow-Up

Patients who experienced a hypertensive emergency are at increased risk of cardiovascular and renal disease.[129,130] Thorough investigation of potential underlying causes and assessment of HMOD is mandatory to avoid recurrent presentations with hypertensive emergencies. Similarly, adjustment and simplification of antihypertensive therapy paired with advice for lifestyle modification

will assist to improve adherence and long-term BP control. Regular and frequent follow-up (monthly) is recommended until target BP and ideally regression of HMOD has been achieved.

10.5 Ethnicity, Race and Hypertension

Hypertension prevalence, treatment and control rates vary significantly according to ethnicity. Such differences are mainly attributed to genetic differences, but lifestyle and socioeconomic status possibly filters through into health behaviors such as diet – which appear to be major contributors.

Populations From African Descent

- Black populations, whether residing in Africa, the Caribbean, United States, or Europe, develop hypertension and associated organ damage at younger ages, have a higher frequency of resistant and nighttime hypertension, and a higher risk of kidney disease,[131] stroke, HF, and mortality,[132] than other ethnic groups.
- This increased cardiovascular risk may be due to physiological differences including a suppressed RAAS,[133,134] altered renal sodium handling,[135] increased cardiovascular reactivity,[136] and early vascular aging (large artery stiffness).[137]
- Management of hypertension:
  - Wherever possible, annual screening for hypertension is advised for adults 18 years and older.
  - Lifestyle modification should place additional focus on salt restriction, increased intake of vegetables and fruits (potassium intake), weight management, and reducing alcohol intake.
  - First-line pharmacological therapy is recommended as a single pill combination including a thiazide-like diuretic plus CCB or CCB plus ARB (see Sections 8 and 12).[71,138]
  - Among RAS-inhibitors, ARBs maybe preferred as angioedema is about 3 times more likely to occur with ACE inhibitors among black patients.[139]

Populations From Asia

- Ethnic-specific characteristics are recognized for East Asian populations. Hypertensive patients have a greater likelihood of salt-sensitivity accompanied with mild obesity. When compared to Western populations, East Asian people present a higher prevalence of stroke (particularly hemorrhagic stroke) and nonischemic HF.[1]
- Morning hypertension and nighttime hypertension[140] are also more common in Asia, compared with European populations.
- South Asian populations originating from the Indian subcontinent have a particularly high risk for cardiovascular and metabolic diseases, including CAD and type 2 DM. With large hypertensive populations residing in India and China, clinical trials in these populations are required to advise whether current treatment approaches are ideal.[141,142]
- Management of hypertension:
  - South East Asia: Standard treatment as indicated in these guidelines is advised, until more evidence becomes available.[138]

Section 11: Resources

- 2018 European Society of Cardiology/European Society of Hypertension Guidelines [Williams B, Mancia G, Spiering W, et al. 2018 ESC/ESH Guidelines for the management of arterial hypertension: The Task Force for the management of arterial hypertension of the European Society of Cardiology and the European Society of Hypertension: The Task Force for the management of arterial hypertension of the European Society of Cardiology and the European Society of Hypertension. *J Hypertens* 2018; 36(10): 1953–2041.]: These comprehensive and evidence-based guidelines form a complete detailed resource.
- 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/AphA/ASH/ASPC/NMA/PCNA Guidelines [Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High blood pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Hypertension* 2017; 71(6):e13–e115.]: The Guidelines from the United States of America, which attracted much comment on redefining hypertension, is very comprehensive and evidence-based, and largely in agreement with the 2018 European guidelines.
- Weber MA, Poulter NR, Schutte AE, et al. Is it time to reappraise blood pressure thresholds and targets? Statement from the International Society of Hypertension–a global perspective. *Hypertension* 2016; 68:266–268.
- Clinical Practice Guidelines for the Management of Hypertension in the Community A Statement by the American Society of Hypertension and the International Society of Hypertension. [Weber MA, Schiffrin EL,White WB et al. The Journal of Clinical Hypertension 2014; 16(1):14–26].
- NICE Guideline: Hypertension in adults: diagnosis and management. Published: 28 August 2019 www.nice.org.uk/guidance/ng136.
- The Japanese Society of Hypertension Guidelines for the Management of Hypertension (JSH 2019). *Hypertens Res* 2019; 42:1235–1481 https://doi.org/10.1038/s41440-019-0284-9.
- 2018 Chinese Guidelines for Prevention and Treatment of Hypertension – A report of the Revision Committee of Chinese Guidelines for Prevention and Treatment of Hypertension. Liu LS, Wu ZS, Wang JG, Wang W. *J Geriatr Cardiol* (2019) 16: 182–241.
- Guidelines on the management of arterial hypertension and related comorbidities in Latin America. Task Force of the Latin American Society of Hypertension. *J Hypertens* 2017, 35:1529–1545.
- 2019 ESC/EAS Guidelines for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk. [Mach F, Baigent C, Catapano AL et al. *Eur Heart J* 2020;41:111–188. doi:10.1093/eurheartj/ehz455].
- 2019 ESC Guidelines on diabetes, prediabetes, and cardiovascular diseases developed in collaboration with

the EASD: The Task Force for diabetes, prediabetes, and cardiovascular diseases of the European Society of Cardiology (ESC) and the European Association for the Study of Diabetes (EASD). [Cosentino F, Peter J, Grant PJ, Aboyans V et al. *Eur Heart J* 2020; 41:255–323, https://doi.org/10.1093/eurheartj/ehz486].

- The HOPE Asia Network contributes largely to evidence for this region: [Kario K et al. HOPE Asia (Hypertension Cardiovascular Outcome Prevention and Evidence in Asia) Network. The HOPE Asia Network for "zero" cardiovascular events in Asia. *J Clin Hypertens* 2018; 20:212–214].
- World Health Organization, HEARTS Technical Package: [https://www.who.int/cardiovascular_diseases/hearts/en/]: The HEARTS package contains free modules (in English, French, Spanish, and Russian) on, for example, healthy-lifestyle counseling; Risk based charts, but particularly for Team-based care which is particularly relevant in low resource settings where task-sharing is highly relevant: https://apps.who.int/iris/bitstream/handle/10665/260424/WHO-NMH-NVI-18.4-eng.pdf;jsessionid=7AC6EC215FEB390CBD93898B69C4705C?sequence=1.
- Cardiovascular Risk Scores: Several scoring systems are available. Some are based only on European populations, for example, SCORE.
  - SCORE: http://www.heartscore.org/en_GB/access The following scores also take ethnicity into account.
  - QRISK2: https://qrisk.org/2017/index.php
  - ASCVD: https://tools.acc.org/ldl/ascvd_risk_estimator/index.html#!/calulate/estimator/
- World Heart Federation Roadmap to the Management and Control of Raised Blood Pressure provides guidance on achieving the target of a relative reduction of the prevalence of raised blood pressure by 25% by 2025: https://www.world-heart-federation.org/cvd-roadmaps/whf-global-roadmaps/hypertension/
  - Based on this Roadmap, an Africa-specific roadmap was also developed: [Dzudie A, Rayner B, Ojji D, Schutte AE, et al. Roadmap to achieve 25% hypertension control in Africa by 2025. *Global Heart* 2018; 13:45–59].

Listings of Validated Electronic Blood Pressure Devices That Were Independently Assessed for Accuracy

- STRIDE BP: https://stridebp.org/
- British and Irish Hypertension Society: https://bihsoc.org/bp-monitors/
- German Hypertension Society: https://www.hochdruckliga.de/messgeraete-mit-pruefsiegel.html
- Hypertension Canada: https://hypertension.ca/hypertension-and-you/managing-hypertension/measuring-blood-pressure/devices/
- Japanese Society of Hypertension: http://www.jpnsh.jp/com_ac_wg1.html.

Blood Pressure Management in Pediatric Populations

- Flynn JT, Kaelber DC, Baker-Smith CM, et al. Clinical practice guideline for screening and management of high blood pressure in children and adolescents. *Pediatrics* 2017; 140: e20171904.
- Lurbe E, Agabiti-Rosei E, Cruickshank JK, et al. 2016 European Society of Hypertension guidelines for the management of high blood pressure in children and adolescents. *J Hypertens* 2016; 34:1887–1920.
- Xi B, Zong X, Kelishadi R, Hong YM, et al. Establishing international blood pressure references among nonoverweight children and adolescents aged 6 to 17 years. *Circulation* 2016; 133:398–408.
- Dong Y, Ma J, Song Y, Dong B, et al. National blood pressure reference for Chinese Han children and adolescents aged 7 to 17 years. *Hypertension* 2017; 70:897–890.

Section 12: Hypertension Management at a Glance

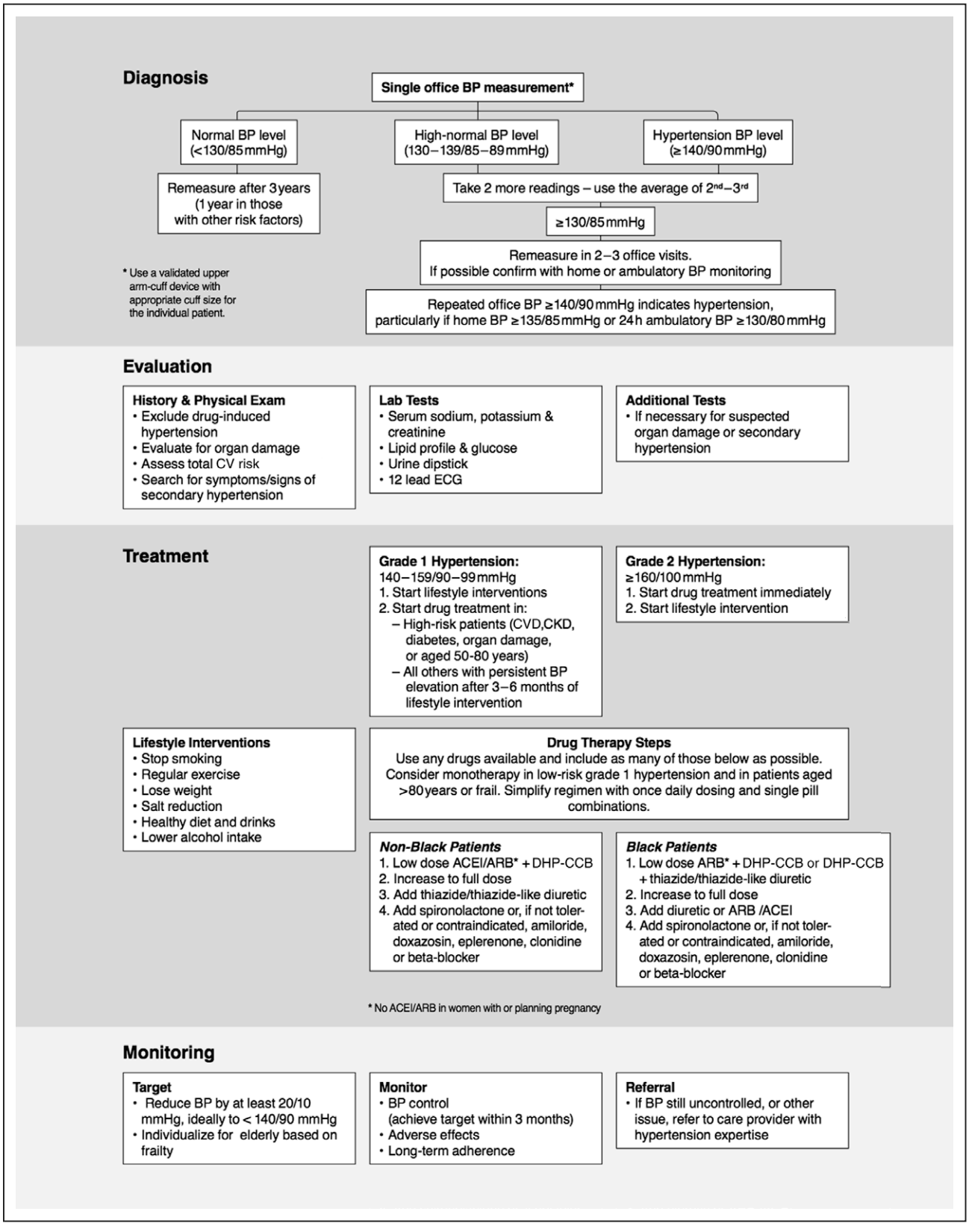

Figure 5. ISH 2020 ESSENTIAL recommendations (minimum standards of care).

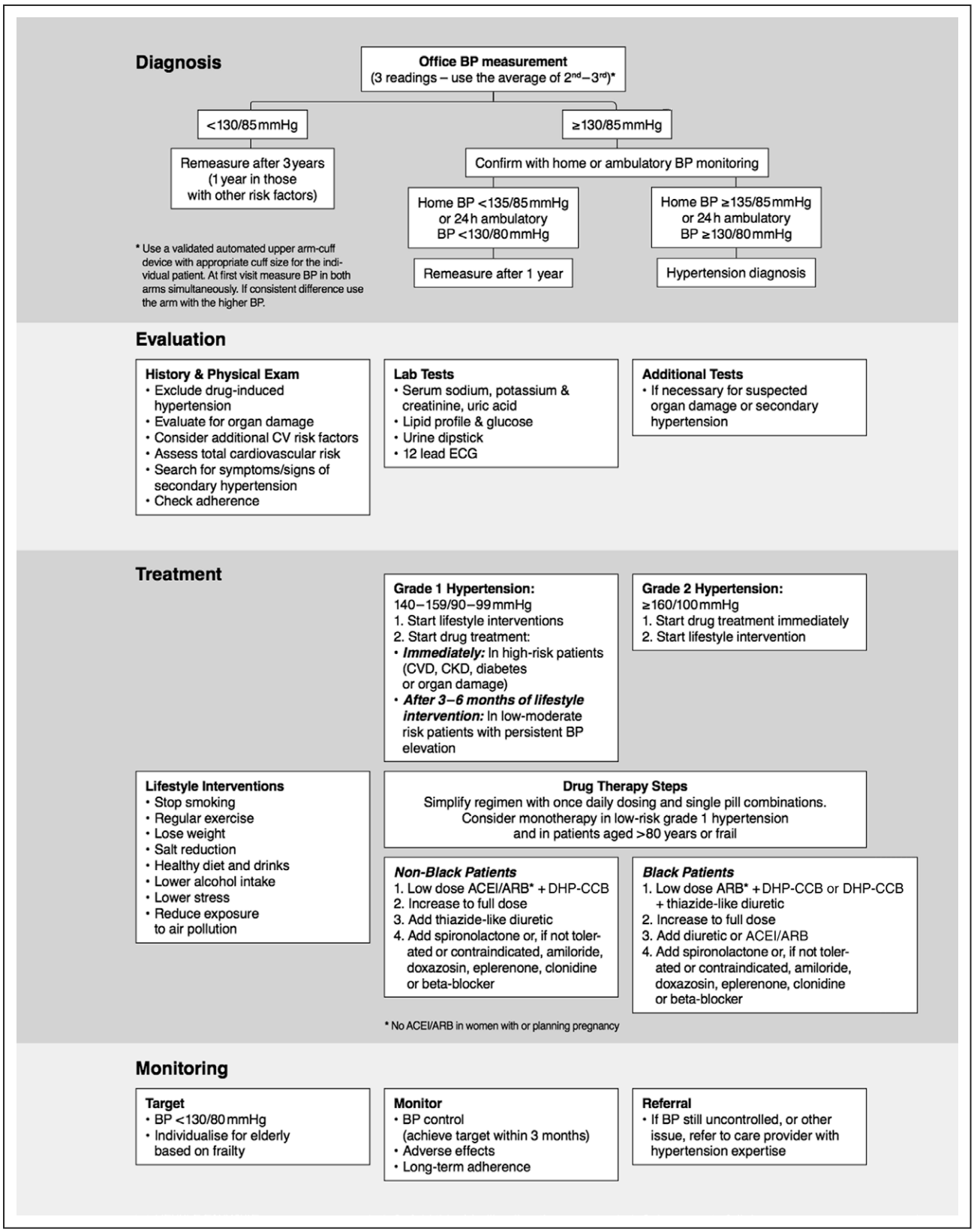

Figure 6. ISH 2020 OPTIMAL recommendations (evidence-based standards of care).

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HEDIS Response Template: Instructions

1. On the ~~NCQA Star Ratings~~ NCQA's Health Insurance Plan Ratings (NCQA Star Ratings) sheet, at the top, insert Proposer's name.
2. On the NCQA Star Ratings , enter details for all of the Proposer's Medicaid managed care contracts, including the Overall, Consumer Satisfaction, Prevention, and Treatment sub-ratings from the NCQA Star Ratings ~~2018-2019~~ most recent Summary Report (Medicaid). The Proposer shall provide complete and accurate information in all fields, consistent with the NCQA Summary Report (Medicaid).
3. The Proposer should include the NCQA Star Ratings information for all Medicaid managed care plans operating in Louisiana.
4. The Proposer should only include NCQA Star Ratings information for Medicaid managed care programs operating outside of LA if the plan's NCQA accreditation is listed as a "YES" on the Medicaid summary report indicating that it has full, non-interim, NCQA Accreditation. The Proposer should NOT include Medicaid plans operating outside of LA: (1) with interim NCQA Accreditation or (2) for which NCQA STAR ratings information was issued at the time of interim NCQA Accreditation.

HEDIS Response Template: Humana Healthy Horizons in Louisiana

Humana Healthy Horizons in Louisiana

							Most Recent NCQA Star Rating Summary (Medicaid) Indicate Year: 2019 - 2020			
Number	State	Medicaid "HMO" Plan Name	Medicaid Enrollment in July 2021	NCQA Accreditation	Populations included (e.g., ABD, TANF, Expansion, LTSS)	Benefits provided (e.g., full benefits, behavioral health only, Medicare/Medicaid integrated)	Overall	Consumer Satisfaction	Prevention	Treatment
1	FL	Humana Medical Plan, Inc. (Florida)	624,808	Yes	TANF/CHIP, ABD, LTSS	Full Benefits	3.5	3.0	3.0	3.0
2	KY	Humana Health Plan, Inc. (Kentucky)	168,844	Yes	TANF/CHIP, ABD, Expansion	Full Benefits	3.0	3.0	2.0	2.5
3										
4										
5										
6										
7										
8										
9										
10										

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Humana Medical Plan, Inc. (Florida)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

12/03/2019	12/03/2022
DATE GRANTED	EXPIRATION DATE

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Humana Health Plan, Inc. (Kentucky)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

11/05/2019	11/05/2022
DATE GRANTED	EXPIRATION DATE

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Humana Health Benefit Plan of South Carolina, Inc.

Medicaid HMO

ACCREDITED NCQA HEALTH PLAN INTERIM

Interim

for basic structure and processes in place to meet expectations for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

05/27/2021	11/27/2022
DATE GRANTED	EXPIRATION DATE

Kingsley House Adult Day Care participants are given the opportunity to socialize, receive nursing services, care management, and personalized nutritious meals and snacks. Participants engage in fun and stimulating daily activities. Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

Section 2.6.12

Value-Based Payment

Humana

Healthy Horizons™
in Louisiana

2.6.12 2.6.12 Value-Based Payment

Humana Healthy Horizons in Louisiana has reviewed and confirms adherence to requirements in **Model Contract Section 2.17**.

2.6.12.1 Value-Based Payment Strategic Plan

Humana has been a leader in establishing value-based payment (VBP) programs across multiple lines of business for more than 30 years. This is based on our ability to get the fundamentals of paying claims accurately and establishing trust with a diverse provider network. We were one of the first health plans nationwide to partner with providers to develop these models. As of June 2021, **Humana has 73,000 primary care providers (PCPs) in more than 1,000 value-based agreements across 43 states and Puerto Rico. In Louisiana, 76% of our Medicare Advantage (MA) enrollees are attributed to PCPs in value-based arrangements.** We aim to surpass this for our Healthy Louisiana Medicaid program enrollees by building programs that consider the population health issues within each region, drive equitable, high quality and high-value care, and are accessible to all providers through **Valued Care Plus (Valued Care+)**, our Medicaid suite of VBP arrangements. As such, our VBP Strategic Plan includes:

Humana has VBP contracts with 64 Medicare provider groups across all 64 Louisiana parishes.

Nationally, Humana's Medicare value-based providers had **29.2% fewer** hospital admissions and **10.3% fewer** ED visits per thousand in 2020.

- Tailored VBP arrangements for all five of the Louisiana Department of [redacted]

Our data analytics tools allow us to stratify metrics by race, ethnicity, and other demographics to assist our providers in addressing health inequities among Medicaid enrollees and improve performance. We will integrate health equity into **Valued Care+** during the life of the Contract and will work with LDH and our Provider Advisory Council (PAC) on the most effective way to do this to further goals of improving health for all Louisianans. By meeting providers where they are with VBP, aligning our models with LDH's population health and quality goals, such as integrated care, leveraging existing programs such as the Managed Care Incentive Payment (MCIP) program, and leveraging our Strategic Plan and deep Louisiana Medicare VBP experience, [redacted] Recent analysis shows that Humana's value-based programs are improving quality and lowering costs in Humana's Louisiana-based MA value-based arrangements: **21.5% cost savings compared to Medicare fee-for-service (FFS) in 2019, driven by a 27.5% reduction in inpatient admissions and 2.5% reduction in emergency department (ED) visits.** In addition, our VBP providers are successful at getting Medicare enrollees in for their primary care and preventive care visits, with **87.5% of assigned enrollees receiving a preventive care visit in 2020.**

Humana's Florida Medicaid VBP and Quality Success
- 63% of providers in our Florida Medicaid plan participate in one of Humana's VBP arrangements
- Nearly 30% of our Florida Medicaid enrollees are assigned to providers in downside risk arrangements
- Our NCQA-accredited Florida Medicaid plan is tied for first in quality among 10 participating Medicaid plans

Valued Care+ VBP Implementation Time Frame and Specific Models by Provider Type

Humana takes a deliberate approach to implementing **Valued Care+** VBP models. **We start by getting the basics right, with timely and accurate claims payment**. This is an important step in building trust, and trust is the gateway to value based partnerships. In Louisiana, we will start with broad models for PCPs and providers who are already participating in VBP. We will expand to more complex models that include other provider types not historically qualified for VBP using our strategic approach to assessing provider readiness. Using this approach, we will implement the models listed in **Table 2.6.12.1** in Louisiana.

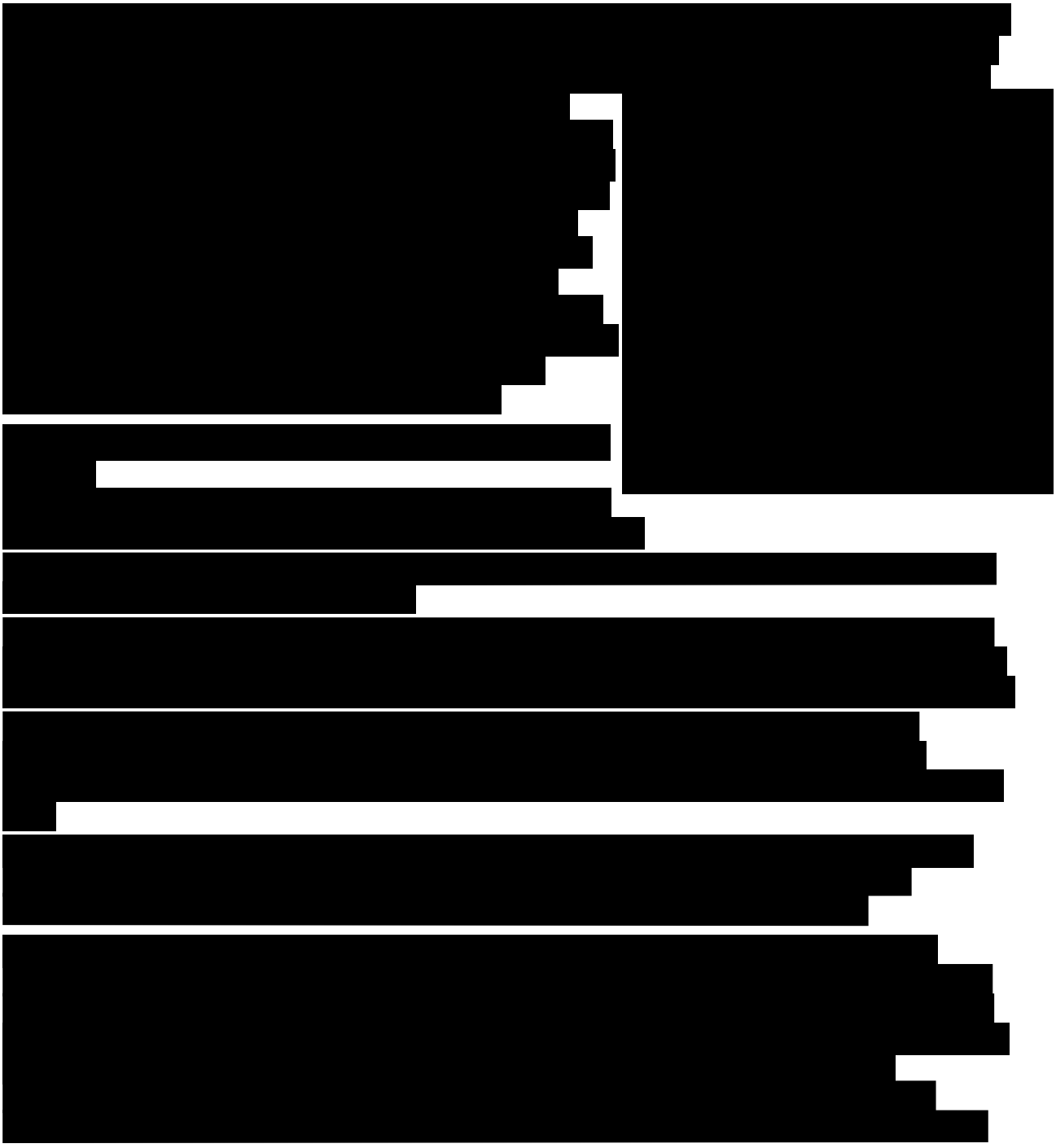
Provider Evolution Along the Alternative Payment Method Model Continuum

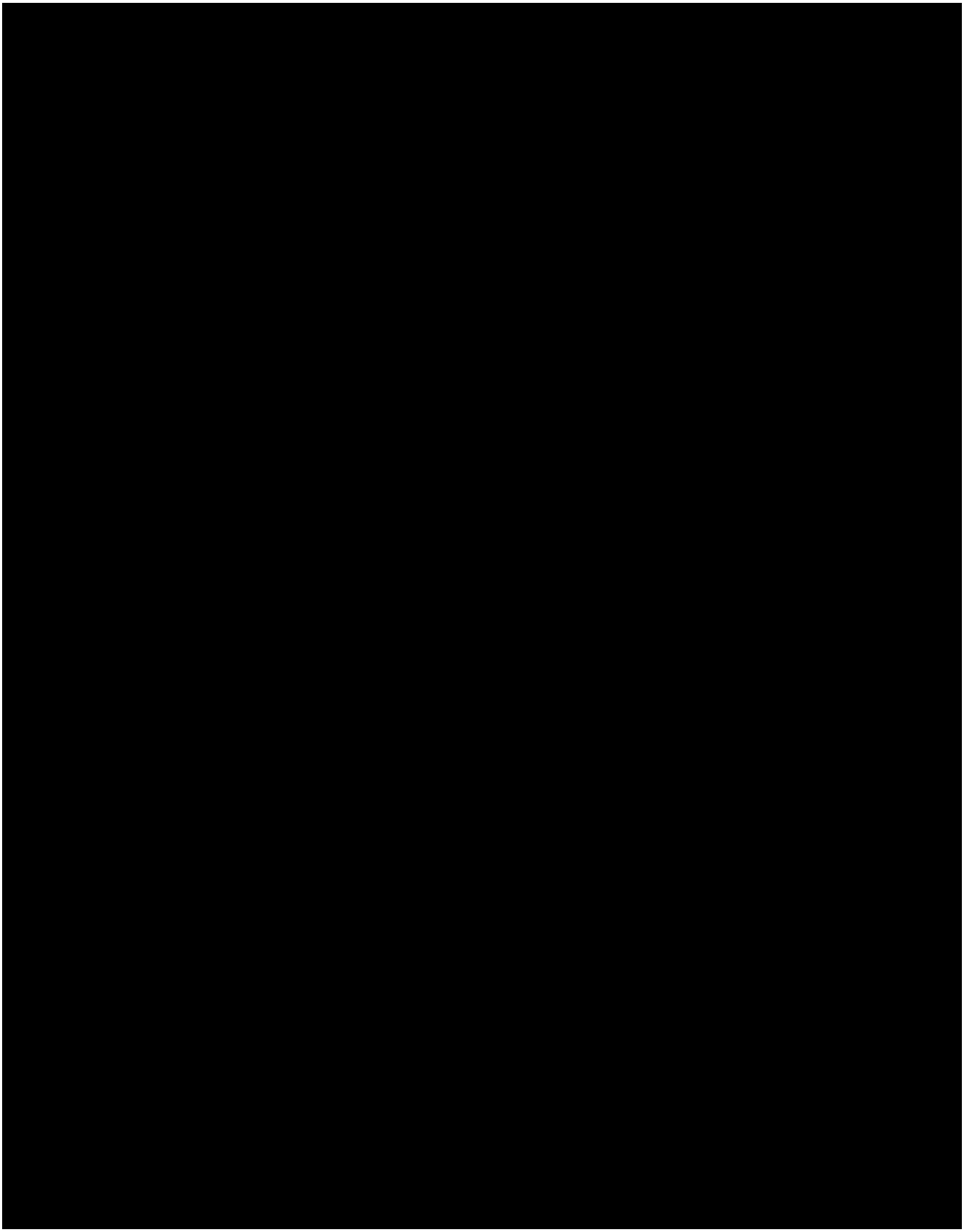
We work closely with providers to transition their practices to an appropriate model based on the Healthcare Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) framework – with actionable data, care coordination, clinical programs, predictive modeling, innovative solutions, and provider supports, as detailed in **2.6.12.3.4**. Humana's **Valued Care+** VBP programs meet providers where they are, giving PCPs, BH providers, OB/GYNs, and hospitals the opportunity to participate to increase their ability to improve quality and reduce costs over time shown in **Figure 2.6.12.1** in our Value Care+ VBP Cycle. Our tailored, flexible models consider individual provider needs, such as federally qualified health centers (FQHC) and Human Services Districts (HSDs), which often have unique billing requirements and limited resources. Our dedicated Medicaid Provider Performance Improvement Advisors (PPIAs) and Practice Transformation Specialists (described in **2.6.12.3.4**) are accountable to individual provider types, and perform readiness assessments to help providers determine the right VBP arrangement for their practice, offering technical and financial support to help them progress into higher level models.

2.6.12.2 Expanding Initial Efforts Through VBP Steps in First Three Contract Years

Humana's strategy to expand and enhance our flexible, tailored **Valued Care+** VBP models throughout the first three years of the Contract includes the following steps:

1. Investing in provider support and practice transformation to ensure readiness
2. Offering a continuum of VBP models to meet providers where they are
3. Diversifying model eligibility criteria to allow for small and rural provider participation
4. Working with innovative provider partners to co-create new VBP models and scaling over time
5. Continually analyzing model effectiveness and provider success.



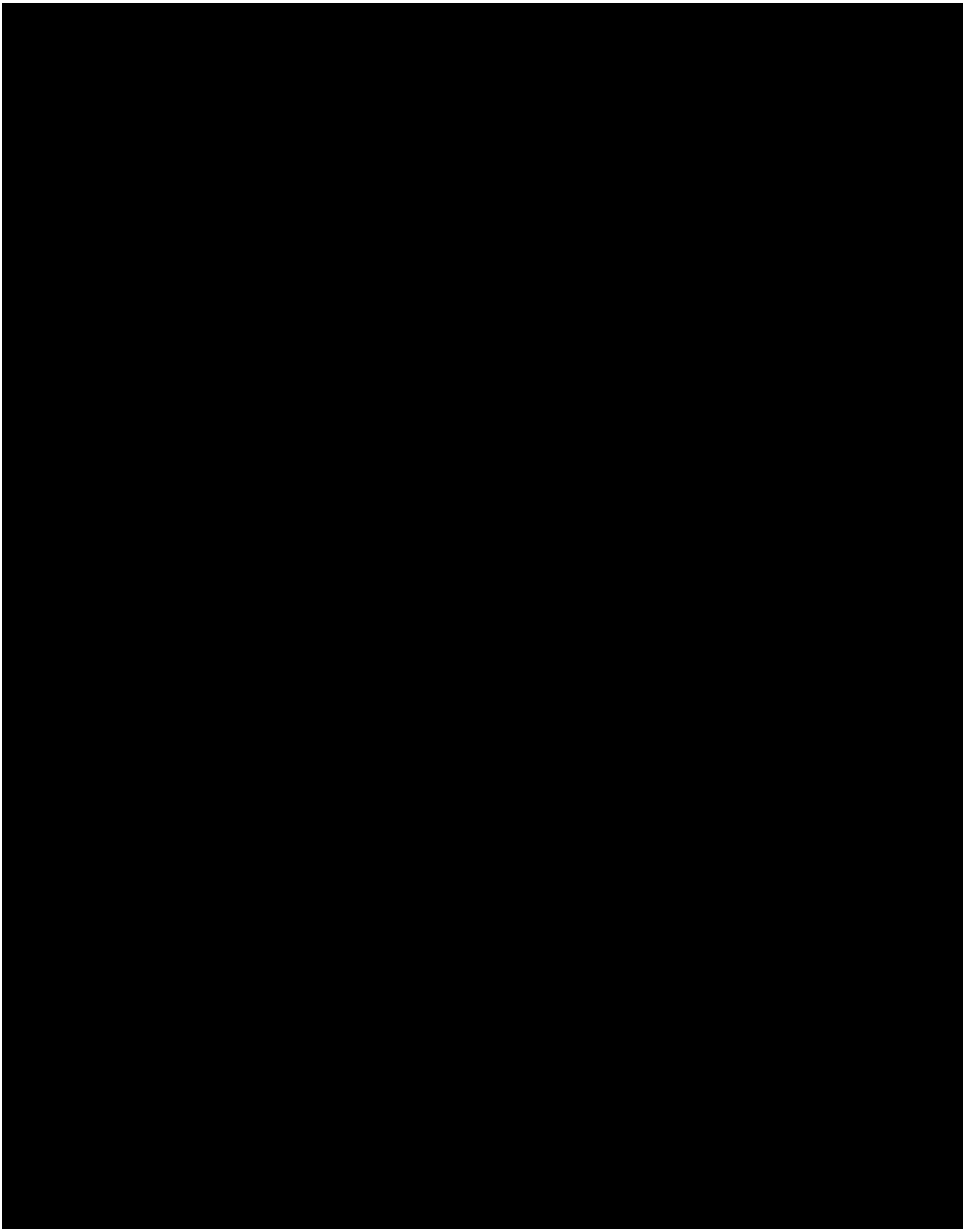


[redacted]

2.6.12.3.2 Quantitative, Measurable, Improvements in Clinical Outcomes

Each stage of our VBP continuum has quality measures and incentives designed to achieve specific outcomes related to the Triple Aim as outlined in **Tables 2.6.12.3-5 through 2.6.12.3-10**. Because VBP enables quality improvement, Humana's VBP strategy aligns with LDH and the Louisiana Medicaid Quality Committee's priorities to improve outcomes across an array of clinical and efficiency metrics such as those included in **Attachment H**. Our plan to implement quantitative, measurable improvements in clinical outcomes complies with **Model Contract Section 2.17.3.4** and includes:

[redacted]



[redacted]

Table 2.6.12.3-11 Louisiana Medicare Valued Care+ VBP Improvements		
Prevention	**Utilization**	**Management & Adherence**
↑ 18% Eye Exams	↓ 27.5% Hospital Admissions	↑ 13% Antidepressant Medication Management (Effective Continuation Phase)
↑ 20% Colorectal Cancer Screenings	↓ 2.5% ED Visits	↑ 49% Blood Pressure Control Management

2.6.12.3.3 Expanding Value-Based Payment Arrangements

Humana's Louisiana VBP experience through our **Medicare 4.5 Star plan** demonstrates that we have the contract structures and provider relations processes in place to extend our VBP programs to Medicaid and exceed LDH's VBP targets. **Our strategy to expand VBP arrangements over the initial years of the Contract includes offering all preferred arrangement categories** identified in **Model Contract Section 2.17.6** and is based on tailored outreach and collaboration with providers. Humana began our outreach and recruitment strategy to expand our Medicaid **Valued Care+** VBP program with Louisiana providers with whom we have established relationships through our Medicare or Commercial programs. Our tailored Medicaid VBP models allow all provider types, including safety net providers such as FQHCs and rural health clinics, to participate and ultimately succeed in higher-level arrangements. For example, [redacted]

> "LCMC and Humana have a long history of working together to serve the citizens of LA. We are currently par in both their Commercial and Medicare Advantage plans and in 2021, we launched a Medicare Advantage narrow network together. Our physicians are also a participating in their value-based programs that help to drive quality and outcomes for the members we serve. We look forward to working with them as Medicaid partners and developing a robust value-based relationship on the Medicaid side as well."
>
> - Bob Remy, VP , Strategy, LCMC Health

2.6.12.3.4 Supporting Providers in Successful Delivery Reform Through Payment Arrangements

Humana's experience in Louisiana with our existing Medicare network demonstrates our ability to move providers along the VBP continuum and enable delivery system reform. **From 2018 to 2020, the number of our covered population in our Model Practice (APM Category 3A) and higher VBP arrangements increased by 611,000.** Our proven strategy for supporting these providers, as well as those new to our network, to succeed in VBP arrangement and advance Louisiana's goals for delivery system reform includes: 1) Proven processes to work collaboratively with providers and assist them in meeting VBP goals and targets; 2) Transparent process to determine provider readiness and infrastructure capacity to move to higher levels on the VBP continuum; 3) Data reporting that provides accurate and actionable data that enables practices to succeed in VBP; and 4) Focused technical assistance to help providers prepare for and succeed at higher level VBP arrangements.

Building Collaborative Relationships with Providers

Humana's new provider support model is foundational to Humana's efforts to build collaborative relationships with providers, and helping them succeed in VBP arrangements through:

Advanced Primary Care Model: We have based our APC model upon the notion that primary care is the backbone of a health system achieving the Triple Aim. Our APC model is open to all PCPs, which gives them: Access to practice transformation resources including practice coaching to enhance capabilities including telehealth and integrated care capacity; insight into quality and performance improvement opportunities; assistance with referrals to help address SDOH; and support with care coordination and integrated care efforts to help treat BH and complex conditions.

Medicaid Provider Performance Improvement Advisors: These regional experts provide quality and VBP support for individual provider types including FQHCs, small and rural health providers, pediatric providers, large provider groups, BH providers, specialists, and OB/GYNs. Each PPIA has specialized training to assist the provider types to which they are assigned, allowing them to appropriately assess provider readiness for participation and advancement in VBP arrangements. For example, [redacted]

Medicaid Practice Transformation Specialists: These experts collaborate with providers to build and strengthen their practice capabilities to deliver more comprehensive care to enrollees and take on increasingly larger degree of accountability in more advanced VBP models. These specialized nonclinical and clinical **Practice Transformation Specialists** provide education and assistance to improve provider capabilities such as BH integration in primary care practices; assist with NCQA/other certification; [redacted]

Recurring Meetings: Humana PPIAs have regular, face-to-face contact with providers to address a range of practice, clinical, and social determinant needs. Through our experience we learned that formal, structured interactions with providers are important to keep provider practices and Humana aligned on our mutual goals. [redacted] These recurring meetings follow an agreed-upon agenda to facilitate active problem solving to meet mutually established goals. In addition to PPIA interactions, these meetings typically include additional Humana associates such as contract management and quality, clinical, and pharmacy experts to best address all issues. We also hold quarterly **Joint Operating Committee** meetings with large provider practices, which are leadership forums that ensure that Humana and our large, high-volume, advanced VBP practices effectively communicate and address issues at the senior practice management and local health plan levels. Our Provider Services Director or Provider Relations Representative and the assigned PPIA responsible for the partnership attend all meetings. Senior leaders from clinical, pharmacy, finance, and operations frequently attend depending on agenda topics.

Providing Technical Assistance and Data Analytics Tools for Providers

Moving into value-based care requires an increase in population health management capabilities and access to accurate, actionable data. We have tailored our **Valued Care+** VBP models to meet providers where they are in this transition and support them with the technical assistance and data tools they need to succeed, in accordance with **Model Contract Section 2.17.5.** Using these tools, physician practices can continue focusing on prevention and improving health outcomes, quality, and cost while elevating the overall experience for their patients, physicians, and care staff.

Tools to Assess and Assist with VBP Readiness:

Readiness Assessment: **Our Medicaid VBP Readiness Assessment** and **Population Health Guide** are tools that facilitate discussions between Humana and providers to identify appropriate VBP arrangements. Our PPIAs leverage these tools to assess providers' potential for growth, infrastructure, engagement, clinical operations, and financial operations. They help each practice analyze current workflows to advance appropriate population health efforts, address unmet care gaps, reduce unnecessary testing, facilitate smart referrals for whole-person support, and leverage enrollee data to gain insights into quality, cost, and utilization performance.

Data Analytics and Reporting to Inform Decision Making

Humana uses the data analytics and reporting tools in **Figure 2.6.12.3** to help providers make informed decisions about enrollee treatment and improve performance in quality and cost reduction.

[redacted]

The ability to stratify data by demographic categories and target interventions for specific populations aligns with our efforts to achieve the NCQA Health Equity Distinction Plus.

Tools to Help Manage Enrollees' Whole-Person Care Needs

Electronic Health Records (EHR)/Health Information Exchange (HIE): Our **HIE payer** platform brings together enrollees, providers, and payers to power value-based care, and **Humana is also committed to connecting with the Greater New Orleans HIE** to increase connectivity to FQHCs and leverage the **Corrections-Community Care Continuum (GC4)**. For smaller practices, we are also working with several **EHR vendors** and third-party integrators.

Closed-Loop Referral Program: Humana's SDOH platform offers closed-loop referrals through its network of CBOs. We will integrate this closed-loop referral system into Compass and advance the capabilities of our partners by connecting clinical and social service providers with network providers, enabling tracking and closing of referrals, and allowing us to incent service providers to follow up and close referrals to social services.

[redacted]

Coding Education: To assist providers in VBP arrangements with coding accuracy, Humana developed the Coding and Documentation Education and Training (CADET) Program. CADET coding educators collaborate with provider practice staff to assess their coding accuracy and establish improved processes. CADET coding educators return to practices on a quarterly basis to conduct audits and refresher training.

Kingsley House Adult Day Care program allows participants the options to engage in recreational and educational activities including: games, cooking demonstrations, arts and crafts, sewing and knitting, music therapy, exercise programs, computer classes, line dancing, intergenerational programming with our Early Learning students, and themed parties and events. Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

Section 2.6.13

Claims Management and Systems and Technical Requirements

Humana

Healthy Horizons™
in Louisiana

2.6.13 2.6.13 Claims Management and Systems and Technical Requirements

Humana Healthy Horizons in Louisiana has determined that our robust systems meet or exceed all requirements described in **Model Contract Section 2.18**, **Section 2.19, the MCO Manual, the MCO System Companion Guide, the Department of Justice (DOJ) Settlement Agreement, applicable State administrative rules, and statutes**.

2.6.13.1 Customizing Louisiana Medicaid Specific System for Adjudicating Claims

At Humana, we view every claim as an opportunity to reinforce our commitment to **Pay It Right the First Time**, thereby aiming to adjudicate and reimburse claims correctly at or near the point of service. We have designed our claims strategy to meet the ultimate goals of ensuring our enrollees receive quality care; reducing complexity and administrative burden of the providers; and being an effective State partner in administering Medicaid covered services. Driven by these goals, we have ongoing efforts to enhance the electronic claims submission process to improve provider satisfaction related to claims processing. These enhancements have reduced manual intervention and improved the consistency and accuracy of payments, which is evident through the **consistent demonstration of our ability to maintain an auto adjudication of 90% or higher over the last two years.** Humana has invested in our claims processing tools and technologies, which has helped us be operationally nimble and allow us to accurately respond to program changes or State needs. For example, our Claims Decision Engine (CDE) accelerates the system configuration process to reduce costs and ensure timely implementation. With CDE, we can configure more State-specific requirements without hard coding them within our proprietary claims processing system, Claims Adjudication System (CAS).

> 2021 Florida Medicaid provider satisfaction survey showed 98% of our Florida providers are satisfied with our claims submission process.

Humana manages medical, behavioral health (BH), and long-term care, which ensures consistent claims processing practices. We are prepared to engage with the State's single pharmacy benefit manager (SPBM) to ensure proper implementation of all required activities, including but not limited to medication therapy management, case management, pharmacy lock-in coordination, and payment to the PBM for pharmacy claims and transaction fees. Over the years this experience, coupled with our agile system, has enabled us to quickly prioritize and modify business rules required for contractual compliance, fee schedule updates, and subcontractor integrations. For example, within a 24-hour period in our Florida Medicaid Managed Care Program, we edited our claims authorizations to allow payment to providers of Early Intervention Services (EIS) for children with special needs. Subsequently, we trained our claims adjusters on the EIS program and the edits required to enable this important service. Another recent example occurred with Commonwealth of Kentucky Medicaid, when Humana altered Medicaid claims processing during the COVID-19 pandemic. The Claims Processing team, in collaboration with our Compliance, Provider Payment Integrity, Special Investigation Unit (SIU), and Fee Schedule Management teams worked to review and ensure compliance to federal, State, and COVID-19 guidelines. **We used business configuration tools to create more than 100 new rules to accommodate COVID-19 claim requirements and updated 105 CDE rules**. We also wrote six new payment policies, which have allowed us to quickly change processes to pay claims appropriately. The teams met daily to identify any issues or specific concerns or trends identified in the system-generated reports that track specific codes. This collaboration between our operational and IT teams involved activities such as loading and pricing new billing codes, implementing new reimbursement policies, answering provider inquiries, and supporting code edits.

As we enter the Medicaid landscape of Louisiana, **we will build upon the successful processes and operations already in place from our readiness work completed in preparation for the Healthy Louisiana Medicaid program Contract in 2019**. We already enhanced our claims system based upon the

2019 Louisiana Department of Health (LDH) contract requirements. Using our business rules engine, the CDE enabled us to efficiently perform coding changes to ensure accuracy and align with billing guidelines set forth by LDH. Through our Enterprise Release Management process, we deployed system changes in accordance with our System Development Lifecycle (SDLC) framework, designed to ensure delivery of quality information systems with speed and agility. Using these processes, some of the claims enhancements and upgrades we completed in 2019 for Louisiana (shown in **Table 2.6.13.1-1**) include, but are not limited to, the following:

Table 2.6.13.1-1: Claims Enhancements/Upgrades

2019 Enhancements for LDH	
Set up for Traditional Explanation of Remittance letter to providers	Created new edits and modified existing edits for claims processing and verification
Prepared system to auto-validate claims based on LDH requirements	Updated system to enhance BH claims processing
Designed reporting capabilities to accurately reflect all Louisiana Service Level Agreements	Capability to process claims for Dual enrollees, so that claims from Medicare will pass directly to Humana to pay secondary
Enhanced claims systems to not deny claims for no Explanation of Benefits/Explanation of Benefits (Medicare) when claims are for prenatal care for pregnant women as defined by HPA 16-17	Cover preventive pediatric services as defined by HPA 16-17; or for a service provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency

Our Claims Processing Team, Provider Payment Process team and the Payment Integrity team thoroughly analyzed the new LDH-specific requirements, the **Model Contract**, and the **MCO Manual** to identify specific customizations. We continuously seek to identify and incorporate opportunities for enhancing our encounters submission process. Humana has the capability to submit HIPAA-compliant encounter data to Louisiana's fiscal intermediary based upon the requirement outlined in **Model Contract Section 2.18.15**. We will coordinate all processes on submissions, reception of encounters data, and LDH's acknowledgements through the fiscal intermediary. Humana's Relationship Manager will oversee subcontractors to ensure LDH encounters submission requirements are adhered to continually. We will configure our systems to meet Louisiana-specific provider payment arrangements, like full Medicaid payment and the Managed Care Incentive Payment Program. **We are confident that our claims system will be ready to meet all LDH requirements** and will work closely with LDH to implement any additional, new system enhancements. The Claims Administrator will be responsible for administration of a comprehensive claims processing system capable of paying claims in accordance with the State and federal requirements. Under leadership of the Claims Administrator, Humana Healthy Horizons in Louisiana will establish a team of experts with deep experience in our claims processing operations for Louisiana.

Experienced Claims System Capabilities Meeting the Contract Adjudication Requirements

Humana's prompt, timely, and accurate claims payment is key to reducing provider burden and maintaining strong provider relationships, evidenced in **Table 2.6.13.1-2**. Humana uses a direct and collaborative approach with the states and their clearinghouses related to Medicaid claims and encounters. With the exception of the current COVID-19 pandemic, Humana meets both in person and via conference calls with all of our state clients as often as required or necessary. These discussions provide Humana, the states and their clearinghouses the opportunity to go over any and all issues that may exist with encounters or claim edits in place, along with any other issue that may impact encounter submissions. This allows Humana to make direct changes in processes, procedures, and technical changes to our systems to meet the State's needs.

While we also accept paper claims, we proactively encourage providers to submit and receive claims information through electronic data interchange. **As a result of our education and training efforts, the volume of claims submitted electronically in our Florida Medicaid Program increased from 95.3% in 2019 to 97.8% in the first half of 2021. Currently we process provider payments made via check, per provider preference, twice per week, and will follow the same for Louisiana, exceeding the LDH requirement. Providers who choose to be paid via EFT will receive payment daily.** As our electronic hub (eHub), the system that performs an initial data analysis, receives a claim, it then routes to CAS, as shown in **Attachment 2.6.13.1 Claims Adjudication Process**. Upon receipt, CAS returns an electronic acknowledgement and maintains 100% traceability between systems to ensure no claim is lost. As needed, CAS matches claims with authorizations. If CAS does not find an authorization, the system returns the 837 file with a note of resubmission to the provider. CAS determines whether the claim includes all information necessary for adjudication and for our subsequent encounter submissions to the State. Our system edits meet Centers for Medicare & Medicaid Services (CMS) mandated edits for the State's Medicaid program as well as nationally recognized clinical editing standards. Our providers can check claims status in Availity, our provider portal. If they need assistance, they can call our Provider Services Call Center or their assigned Provider Relations Representative. We also offer high-touch service, where our Provider Relations Representatives and Provider Claims Educators work in-person with providers to assist and guide them with claims issues. We will conduct monthly meetings to review changes to edits based upon feedback from the Louisiana provider community. We categorize claims that pass the edits in our CAS as clean claims. We automatically process finalized claims for payment.

We make daily payments along with electronic remittance advice (ERA) to our providers if they enroll in electronic funds transfer (EFT)

Table 2.6.13.1-2: Humana's Claims Adjudication Rate

Year	Clean Claims paid within 15 days	Clean Claims paid in 30 days	Clean Claims paid in 60 days
2020	94.6%	98.9%	99.8%
2019	97.6%	99.6%	99.9%

To ensure accuracy of claims payment for Louisiana Medicaid, our Quality Audit team will conduct a prepay audit prior to finalizing a claim, which will reduce any recovery provider abrasion, especially on high-dollar claims. Our Service Quality Organization team protects Humana from the full spectrum of healthcare fraud, waste, and abuse (FWA) by performing root cause analysis and determining the origin of a defect. Prepay audits are based upon rules we have developed for end-to-end criteria and coded in our system. We perform pre-disbursement audits on high-dollar claims or when a payment exceeds $750,000. Once we identify such claims, we perform an end-to-end audit and provide feedback to operations. After proper analysis on the accuracy, we release the claim for payment. The Claims Quality team audits close to 60,000 claims per year. The total paid dollars audited monthly is approximately $15M and annually $180M. **For Louisiana, we will complete a separate monthly audit to ensure we maintain accuracy, per Louisiana guidelines, and proactively identify claims payment issues**.

2.6.13.2 Management Information System Overview

Today our MIS supports over 5 million enrollees in our Medicare Advantage and Medicaid programs.

Humana maintains an integrated, automated Management Information System (MIS) to support the complex demands of our health coverage and care coordination activities for physical health, BH, and social determinants of health (SDOH) services. Our MIS, which incorporates the aforementioned CAS, is grounded by Humana's overarching focus on enhancing enrollees' outcomes and quality of life. We recognize that well-functioning information technology (IT) is the backbone of our business functions; it is foundational for identifying opportunities to assist enrollees in their care and to deliver providers accurate and timely payment. Our MIS accepts and processes provider claims, verifies eligibility,

facilitates population health and care management, collects and reports encounter data, and validates prior authorization and pre-certification compliant with LDH and federal reporting requirements. Humana's technology helps limit financial burdens on enrollees and assists in addressing SDOH and health disparities in communities. Driven by the goal of integrated care delivery, we support contemporary interoperability using fast healthcare interoperable resources (FHIR) and similar approaches. Humana continuously invests while leveraging employee innovation in the fields of data and interoperability, advanced analytics, artificial intelligence, and virtual care. **In 2019, Humana and Microsoft Corporation announced a strategic partnership focused on building modern healthcare solutions for Humana enrollees aimed at improving their health outcomes and making their healthcare experiences simpler to navigate.** We launched a new data analytics and digital health division, Humana Studio H, that integrates our big data and health IT strategies. Studio H enabled our speedy and effective implementation of our COVID-19 response.

Humana's critical systems availability for 2021 is 99.57%

2.6.13.2.1 Length of Time Humana Has Used Proposed Management Information System

The stable, integrated and compliant MIS we will bring to Louisiana Medicaid has been operational for more than two decades, continuously evolving as we invest to respond to the needs of the populations we serve and to keep current with modern technologies. We have successfully deployed this MIS in Florida, Virginia, South Carolina, Kentucky, and Illinois for Medicaid Temporary Assistance for Needy Families (TANF) and Aged, Blind and Disabled (ABD) and LTSS, and in 26 states for Dual Eligible Special Needs Program (D-SNP). Our MIS reliably serves more than five million Medicare Advantage (MA) and Medicaid enrollees. Humana's applications successfully enable the workflows necessary to manage enrollee and provider interactions to improve business processes and quality of care.

2.6.13.2.2 Hardware and System Architecture Specifications for All Systems

Table 2.6.13.2-1 provides a brief description of the systems and their hardware architecture that we will use to support Louisiana Medicaid. All platforms are on current releases; none is unsupported. **Attachment 2.6.13.2-1 High Level System Architecture** provides an overview of the **system architecture** for the system as a whole. **Attachment 2.6.13.2-2 Key System Architecture** includes the architecture for key systems, including enrollee and provider enrollment, claims processing, customer service systems, utilization management (UM)/service authorization, Care Management/care coordination, and financial systems.

Table 2.6.13.2-1 Hardware Architecture Specifications

Hardware Component	Hardware Specifications
Data Center	Designed to conform to the Uptime Institute's Level 4 (highest) standards for resilience and redundancy. Also utilizes the three major cloud vendors: Microsoft Azure, Amazon Web Services, and Google Cloud Platform
Data and Voice Network	The LDC network is built primarily on Cisco equipment, with some Arista components. Offices and clinics Cisco SD-WAN, with Cisco and Meraki for wireless
Server	Mainframe – IBM Z15 Series UNIX – Releases 7 and 8 Windows - Windows 2019. Virtualized via VMWare AIX - Versions 7.1 and 7.2
Storage	Storage platforms, including Cisco, Dell EMC, IBM, Pure Storage, and NetApp. All storage utilizes AES-256 encryption.

2.6.13.2.3 Proposed Functions and Interfaces

Humana currently operates all enterprise systems required for the Louisiana Medicaid program including other Medicaid contracts and our MA and commercial lines of business. **Table 2.6.13.2-2**

Proposed Functions and Description describes the MIS modules or the proposed functions designed to support the needs of LDH's program and required functional areas.

Table 2.6.13.2-2 Proposed Functions and Description

Functional Area to support this Contract	System	Description
Enrollment (Enrollee and Provider)	**Electronic Transmission (ET)**	ET manages all file transfer requests and transmissions into and out of Humana.
	Customer Interface (CI)	CI receives enrollment and disenrollment data from in-house data mapping and validation modules; houses plan and enrollee-level data; source system of record for downstream systems.
	MedRecon	MedRecon is the reconciliation system for state capitation payments for Medicaid and Duals Demonstration plans.
	Operational Data Store (ODS)	ODS is an integrated, frequently changing, subject-oriented and updatable set of operational data. It powers real-time transactions and web applications, including MyHumana (all portals), Availity, interactive voice response (IVR), CRM, and Smart Summary. ODS is accessible 24x7.
	Master Data Management (MDM)	MDM is the technology, tools, and processes required to create and maintain consistent and accurate lists of critical data to an organization. It assigns a lifetime ID to Humana enrollees regardless of line of business creating a longitudinal view of all data associated with that enrollee.
Provider Management	**Provider Information Management Systems (PIMS)**	PIMS maintains provider demographic information and credentialing verifications information. It is responsible for producing directories data.
	Provider Master Data Management (PMDM)	PMDM provides mastered data from multiple internal/external sources, resulting in a unique view of each provider.
	Provider Cognitive Services - Watson	Watson supports cognitive agent capability within provider self-service.
	Availity (Provider portal)	Providers use Availity to verify enrollee eligibility, submit and review authorizations and claims, view remittances and compliance, and communicate with Humana.
	Population Insights Compass	Population Insights Compass provides quality, pharmacy, Census, and patient detail reports supporting the provider with value-based payment (VBP) arrangements; Provider Relations teams also use it as a provider Customer Relationship Management (CRM) tool.
	Value-Based Payment (VBP)/ Capitation	This risk-sharing management application is used to control provider reimbursement with selected, assigned, and attributed membership through capitation payments, claims expensing, control of claims payment, and reconciliation.
	Contract Information System (CIS)	CIS is responsible for the build, update, and display of all provider contracts.
Claims & Encounter Processing	**eHub**	Receives claims from more than 200,000 providers nationwide through more than 100 clearinghouses; performs eligibility verification; routes electronic and paper claims (formatted for HIPAA 837) to CAS.
	Edifecs 8x	Generates our encounter data; all outgoing files batched per HIPAA guidelines; Strategic National Implementation Process edits; and CMS- and State-specific requirements.
	Claims Administration System (CAS)	Assesses claims to verify enrollee and provider identity as well as the accuracy and appropriateness of the claim; averages 150 edits per second per claim. Supports processing third-party liability and is updated with the enrollee's primary insurance. If Humana coverage is

Functional Area to support this Contract	System	Description
		secondary, we coordinate benefits with other carriers using National Association of Insurance Commissioners & Tax Equity and Fiscal Responsibility Act rules.
Customer Service Systems	**Customer Relationship Management (CRM)**	SalesForce platform offering Enrollee Services staff a 360-degree enrollee view encompassing administrative and clinical matters important to Enrollee and Provider Services Staff. Provides a complete view of claims, authorizations, referrals, and enrollees' providers.
	MyHumana (Enrollee Portal)	Portal to view claims, view or print member ID cards, complete assessments, view resources for enrollee's health, give electronic consent to share health information, and communicate with Humana. Updates/changes enrollees' assigned primary care provider (PCP), selected communication preferences
	Grievance and Appeals (G&A)	User interface designed for handling G&A and Medicaid State Fair Hearing inquiries; supports contractual requirements; includes integrated inventory management dashboards and customizable letters
	Avaya & Nuance	Includes co-functionality with IVR systems, Avaya & Nuance; automated handling of enrollee and provider calls; three-way calling; authentication and self-service capabilities such as Rx refill, claims status check, order new member ID card
Integration Plus Population Health (Integration+) Platform: Comprehensive platform enabling robust clinical/population health that integrates whole-person view of enrollee, including needs assessment, analytics, Plans of Care, authorizations, health outcomes, and more		
Utilization Management (UM)/Service Authorization and Quality Assurance		**Population Health**: Internal, proprietary integrated tool sets to monitor and track health outcomes and utilization for enrollee populations; supports authorization processes; integrates enrollee data from a variety of sources [claims, Health Needs Assessments (HNAs), biometrics, personal health profiles, lab tests, and results] to support the Clinical Insights engine and analytics
Care Management (CM)/Care Coordination		**ATLAS**: Identifies enrollees needing Care Management. Loads enrollees' relevant information to Rules team (coverage, predictive model scores, age, etc.) and runs business rules
		Clinical Platform: Supplies enhanced capabilities to identify candidates for programs and assignment to Care Management, documents gaps in care, performs assessments, automates tasks and rules based on clinical guidance and State guidelines, automates care planning, tracks enrollee outreach, monitors plan compliance, identifies outcomes for further intervention, and gives Case Managers a 360-degree view of enrollee.
		Clinical Rules and Analytics Engine: Internally managed clinical rules engine allowing care gap reporting to source enrollee alerts, predictive models, and provider reporting on open care gaps and needed preventive services; also supports rapid-cycle quality improvement
Financial Systems	**Oracle EBS Financial Platform**	Supports all financial operations and processing; Incorporates Total Reconciliation Solution (TREC) to perform monthly reconciliations, as well as chain of trust compliance for interfaces coming into the General Ledger
	PayPilot	Processes provider payments
Precise Data Plus (Precise Data+): Data warehouse platform that collects data and generates gold standard reporting.		
Reporting		**Enterprise Data Warehouse (EDW):** Centralizes data from all core operating systems (e.g., enrollment, claims, Care Management, and quality, etc.); enables deep, data-driven insights from several reporting

Functional Area to support this Contract	System	Description
		tools; includes Medicaid Data Mart that gathers Medicaid-specific data for analysis and reporting
		Operational Data Store (ODS): Provides enrollees aggregated coverage, group, and claims operational data for the enterprise
		Clinical Data Mart: Supports both clinical reporting and business intelligence analytics
		Reporting Rules Engine: Source of truth for Humana's HEDIS® results rate progress through the year
		Enterprise Solution Point (ESP): Medicaid-centric reporting to track compliance, accuracy, and timeliness of state reporting
Program Integrity	**Surveillance Utilization Review Module (SURS)**	Construct analytical, statistical, and predictive models to detect FWA; models developed for specific specialties and types of services; data selected based upon investigations, research into specific fraud schemes, and scenarios affecting specific models
	Fraud Investigative Tracking	SIU workflow documentation system, all incoming cases of suspected FWA entered into Fraud Investigative Tracking system
	Total Humana Overpayment Resolution (THOR)	Enhances CAS algorithms for superior, more complex rule-building to expand criteria and call-outs to other claims systems, reducing need for provider recoveries on post-pay
Document Management	**eHub**	Storage of electronic documents where they are indexed, available, and retained at or beyond record retention period; indexing facilitates timely retrieval of images for call center representatives, G&A personnel, and other interested parties.
	Enterprise Measurable Messaging Ecosystem (EMME)	Outgoing mail/fax fulfillment system

Proposed Interfaces

Humana leads the industry in our electronic data interchange (EDI) capabilities. With our deep experience in Medicaid managed care, we understand the need for effective data sharing to process information for eligibility (834), premium/capitation payments (820), provider network directory files (274 or proprietary), claims and encounters (837), authorizations (278), pharmacy encounters (NCPDP), eligibility (270/271), and claim status (276/ 277) inquiries. These base transactions establish the foundation for Humana and Louisiana to share fundamental managed care data. Humana uses Secure File Transfer Protocol (SFTP) transactions, Application Programming Interfaces (APIs), and other methods as needed by LDH and in alignment with relevant federal code. **Humana will implement all Louisiana proposed batch and online HIPAA transactions listed in Model Contract Section 2.19.2.3. Table 2.6.13.2-3** shows many of the electronic interfaces we have established for Medicaid programs in Kentucky, Florida, and Illinois. Where we refer to *State*, this includes State Subcontractors undertaking file transfers. Our Electronic Transmissions department's sole purpose is to fulfill inbound and outbound data feeds. We take all appropriate security measures to protect data and monitor data feeds in the operational steady state. New data feeds are subject to all applicable SDLC disciplines.

Table 2.6.13.2-3: Experience Establishing Interfaces for Batch and HIPAA Transactions in Other States

File Type	From - To	KY	IL	FL
Enrollment 834 (Daily/Monthly)	State – Humana	Y	Y	Y
Capitation Payment 820 (Monthly)	State – Humana	Y	Y	Y
Provider File (Daily/Weekly)	State – Humana	Y	Y	Y
Humana Provider Network (Weekly)	Humana – State	Y	Y	Y

File Type	From - To	KY	IL	FL
Encounter 837 (Weekly, Monthly)	Humana – State	Y	Y	Y
Enc. Resp. 999, 276/277 (Weekly, Monthly)	State – Humana	Y	Y	Y
NCPDP Rx Enc. Resp. (Weekly, Monthly)	State or PBM – Humana	Y	Y	Y
Historical Claims/Auth (Monthly)	State – Humana	N/A	Y	N/A
Eligibility Inquiry 270, 271 (Daily)	State – Humana	N/A	N/A	N/A
Auth Request/Response 278	Provider – Humana	Y	Y	Y
Claim 837	Provider – Humana	Y	Y	Y
Remittance Advice 835	Humana – Provider	Y	Y	Y
Encounter Response 835	State – Humana	Y	Y	Y

2.6.13.2.4 Data and Process Flows for All Key Business Processes

Attachment 2.6.13.2-3 IT Data Flows shows the overall data and process flows within our systems and among all key business processes.

2.6.13.2.5 Resources Dedicated to Medicaid Management Information Systems Exchanges

[redacted] Our Electronic Transmissions team configures and automates all secure file transfers between Humana, the Louisiana MMIS, its external partners, and customers. Humana's Site Reliability Engineering group monitors all file exchanges to ensure successful transmission or receipt of files. Humana's Operations team, which relies upon and/or consumes data exchanges with the Louisiana MMIS, also monitors file transactions to support integrity and data transmission accuracy of our MIS/File Exchanges.

2.6.13.3 System Changes or Enhancements

Our MIS is fully operational for the Louisiana Medicaid program. However, given the fast pace of technological change, new IT developments present opportunities for us to continuously upgrade and enhance our systems. We invested more than $1 billion over a four-year period to support strategic innovation, including investments in interoperability, advanced analytics, artificial intelligence, and virtual care. Humana follows a monthly and quarterly release schedule for system maintenance across all applications. We perform system changes and maintenance using robust project management and system development processes to ensure upgrades do not result in downtime for enrollees, providers, or our associates. Our Quality testers fully test all releases, including security code reviews. Humana and our subcontractors ensure technology delivery is well planned and implemented through cross-team collaboration and release coordination that does not have any impact to system availability for our enrollees or providers. In compliance to the **Model Contract**, we will notify LDH of any significant updates at least 90 calendar days prior to the projected date of the change, unless otherwise directed by LDH. We will also provide to LDH or its designee a Systems Refresh Plan as part of Readiness Review 60 calendar days prior to implementation of revisions. **Table 2.6.13.3** shows the enhancements we plan to undertake to improve overall capabilities and respond to specific needs of the Louisiana Medicaid program.

Table 2.6.13.3: Enhancements/Upgrades to Systems

System	Description of Enhancement/Upgrades	Status	Completion Date
2.6.13.3.1 Enrollment	**Website/Portal:** Further integration with population health platform to display HNA result	In Progress	EOY - 2024
	Mobile Platforms: Creation of diabetes pathway to support enrollee self-management		EOY - 2024
			EOY - 2024

System	Description of Enhancement/Upgrades	Status	Completion Date
	IVR: Enabled Omni-channel, voice-initiated, personalized interactions to deliver callers to best-skilled Enrollee Services Staff or easy access self-service for both caller and staff		
2.6.13.3.2 Claims Processing	**Claims Engine**: Enhancing back-end claims processing engine to accelerate time to deliver and internal interface performance supporting State-specific customization	In Progress	EOY - 2024
2.6.13.3.3 Utilization Management	**Continuously** leveraging FHIR interfaces for State requirements to support transition of care, disease management, population health, and medication profiles to ensure optimized provider and enrollee experience and care	In Progress	EOY - 2025
2.6.13.3.4 Care Management	**Continuously incorporating State Requirements on the** Integration+ platform and mobile tools to **enhance care to support** enrollee interactions. Further incorporates SDOH insights and metrics into the Integration+ platform	In Progress	EOY - 2025
Cross-Functional	**Cloud Migration**: Deployment of cloud-first tech ecosystem Simplified and hyper-connected full technology ecosystem with modern suite cyber capabilities **Customer Experience Center Platform**: Implementing Omni-channel messaging and experiences to deliver tailored and personalized content based on individual consumer needs	In Progress	EOY - 2024 EOY - 2023

2.6.13.4 Capability and Capacity our System to Interface with LDH's System

Humana's successful implementations of Medicaid programs in multiple states demonstrate our capability to interface with LDH, the Fiscal Intermediary, enrollment broker, and its trading partners as described in **Model Contract Section 2.19.1.19**. We commit to meeting the requirement of allowing and enabling authorized LDH personnel real-time connectivity to our system as remote connections from LDH offices. Humana will leverage our Data Governance department to ensure enrollee data remains secure while also accessible to LDH. We will ensure data remain protected by exchanging through SFTP through the state's FTP/SFTP service, APIs, or other methods as discussed or directed by LDH and in alignment with relevant federal codes. We successfully leveraged this approach with our Florida Medicaid Managed Care plan. We created a business partner portal for Florida's Medicaid agency, the Agency for Health Care Administration, to provide access to claims data and share dashboards. Our QlikView and SSRS dashboards allow for information presented at an aggregate level, with an ability to filter and drill down to the claims level. These tools, available to our state partners, make our reports highly interactive and customizable. Leveraging this experience, Humana looks forward to working collaboratively with LDH. **Our system is well-positioned and scalable to sustain Humana's recent trend of organic membership growth**. Currently, our systems serve nearly 900,000 Medicaid enrollees. In addition, our Medicaid enrollment has grown by more than 110,000 (18%) in 2020. Once we enter the Louisiana Medicaid landscape, we anticipate this will represent less than a 7% increase in the number of enrollees administered on Humana's core systems.

> Through year-over-year growth our systems have scaled to accommodate a membership increase of 1.7 million enrollees over the last three years. In addition, our Medicaid enrollment has experienced a growth of more than 110K (18%) in 2020.

> Humana is the only US health plan that has earned all 7 of CAQH's CORE rule set certifications

Capability and Capacity of our System to Interface with Network Providers and Subcontractors

As an early adopter of the FHIR interoperability standard, we have collaborated with industry-leading workgroups, including the DaVinci Project, FHIR at Scale Task Force, Argonaut Project, the CARIN Alliance, and Project Gravity, tasked with accelerating the adoption of HL7® FHIR ®. We have established relationships with top electronic health

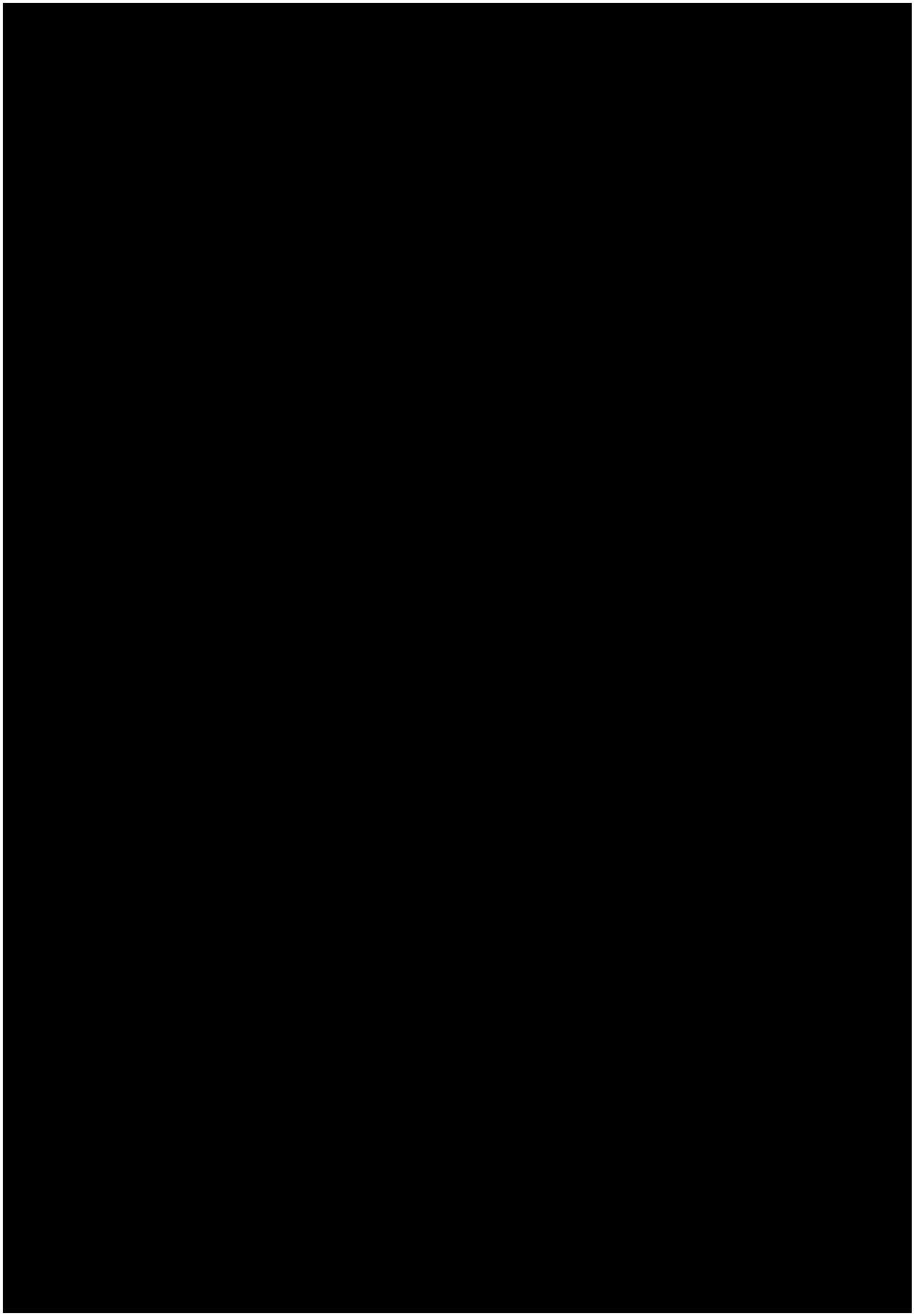
record (EHR) vendors, such as athenahealth, Allscripts, and Epic, allowing us to build direct connections with providers that streamline their daily workflows by developing electronic versions of administrative and clinical requirements. Humana continues to implement and promote interoperability among its providers and enrollees. Currently we are connected with more than 350 provider organizations in Louisiana via direct EHR connections exchange CCDA and/or image data. **We have been working with Louisiana Health Information Network (LHIN) for the exchange of admit, discharge, transfer (ADT) data since January 1, 2020**. Through the exchange of data with LHIN, which receives ADT data from almost all Louisiana hospitals, we meet the contractual requirement in **Model Contract Section 2.19.3.5** to ensure that emergency departments provide data on high drug utilizers, persons exhibiting drug-seeking behavior, and those in need of chronic disease management. Additionally, in fulfillment of contractual requirement in **Model Contract Section 2.17.12.3**, we will enable providers of value-added benefits access to data to assist in service delivery, which will prove especially beneficial to providers offering respite care to enrollees experiencing homelessness. Humana has APIs to permit third-party applications to retrieve enrollee health information with an enrollee's approval and thereby support real-time data exchange with our providers. **We have bidirectional data sharing, both real-time and asynchronous, with providers via connections with EHR systems, State health information exchanges (HIE), and material subcontractors who submit data on dental, vision, BH, and nurse hotlines.** Transactions, include but are not limited to, ADT, CCD (C32, C62, CCDA), and images. We also support providers through HEDIS and gap in care/quality of care transmissions via Humana's platform. This seamless data exchange enables improved enrollee health outcomes while reducing provider burden. Humana allows enrollees to take their information with them as they move from payer to payer over time. This enables the creation of a longitudinal health record with their current managed care organization. Having an enrollee's health information in one place will facilitate informed decision-making, efficient care, and ultimately can lead to better health outcomes.

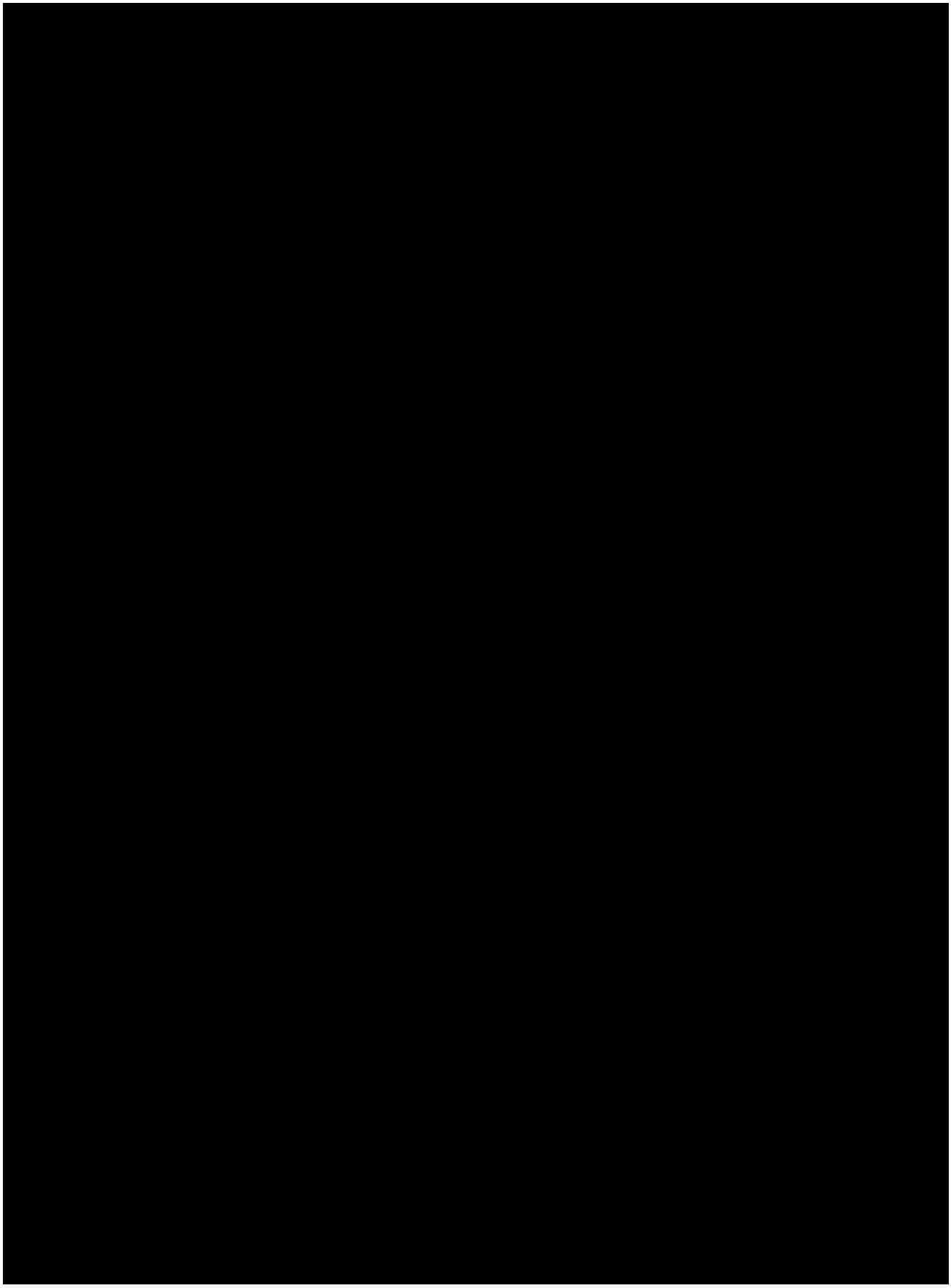
> "The healthcare industry has a great opportunity to band together to answer CMS' call to help deliver a new patient experience. The promise of interoperability is inspiring because, if done right, it will be the foundation for transforming the system."
> – Bruce Broussard, Humana President & Chief Executive Officer (CEO)

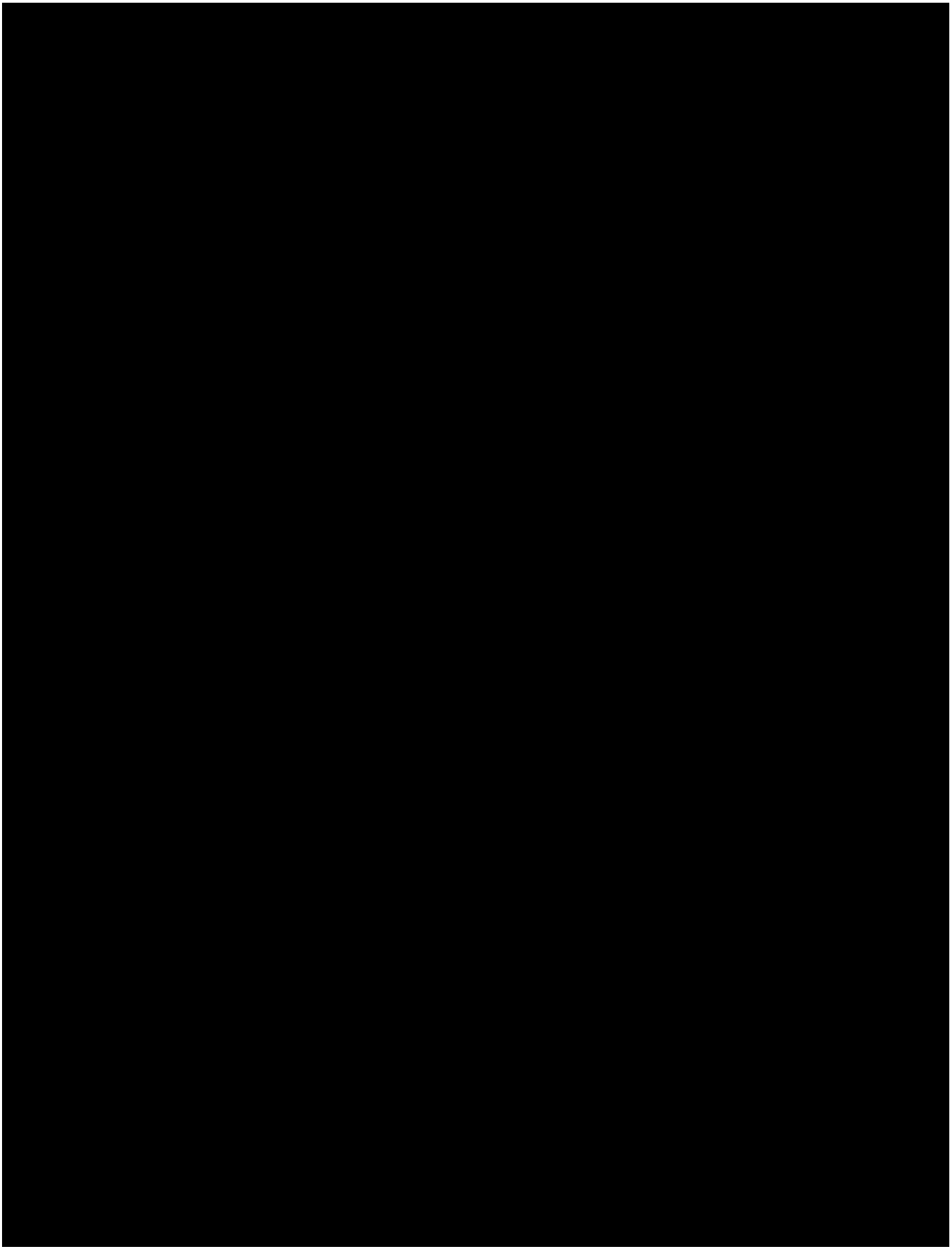
In Louisiana, **we committed to connect with the Greater New Orleans Health Information Exchange** to increase connectivity to federally qualified health centers and leverage the Corrections-Community Care Continuum (GC4). We have engaged with Louisiana Health Information Exchange (LAHIE) and are excited to build upon this relationship to strengthen the capacity of our contracted providers to achieve patient-centered medical home certification. Based upon discussions with Health Sync, which is establishing HIE capabilities in Louisiana, we plan to build data exchange partnerships with provider practices throughout the State. Humana is a founder, and remains a co-owner, of our provider portal, Availity, which operates the largest real-time information network in healthcare, connecting more than two million providers, health plans and their technology partners. Availity makes it possible for providers to migrate from single health plan portals with numerous logins and passwords to the Availity Multi-Payer Provider Engagement Portal. The Availity network of top health plans and premier providers combine to form healthcare's largest, most powerful network.

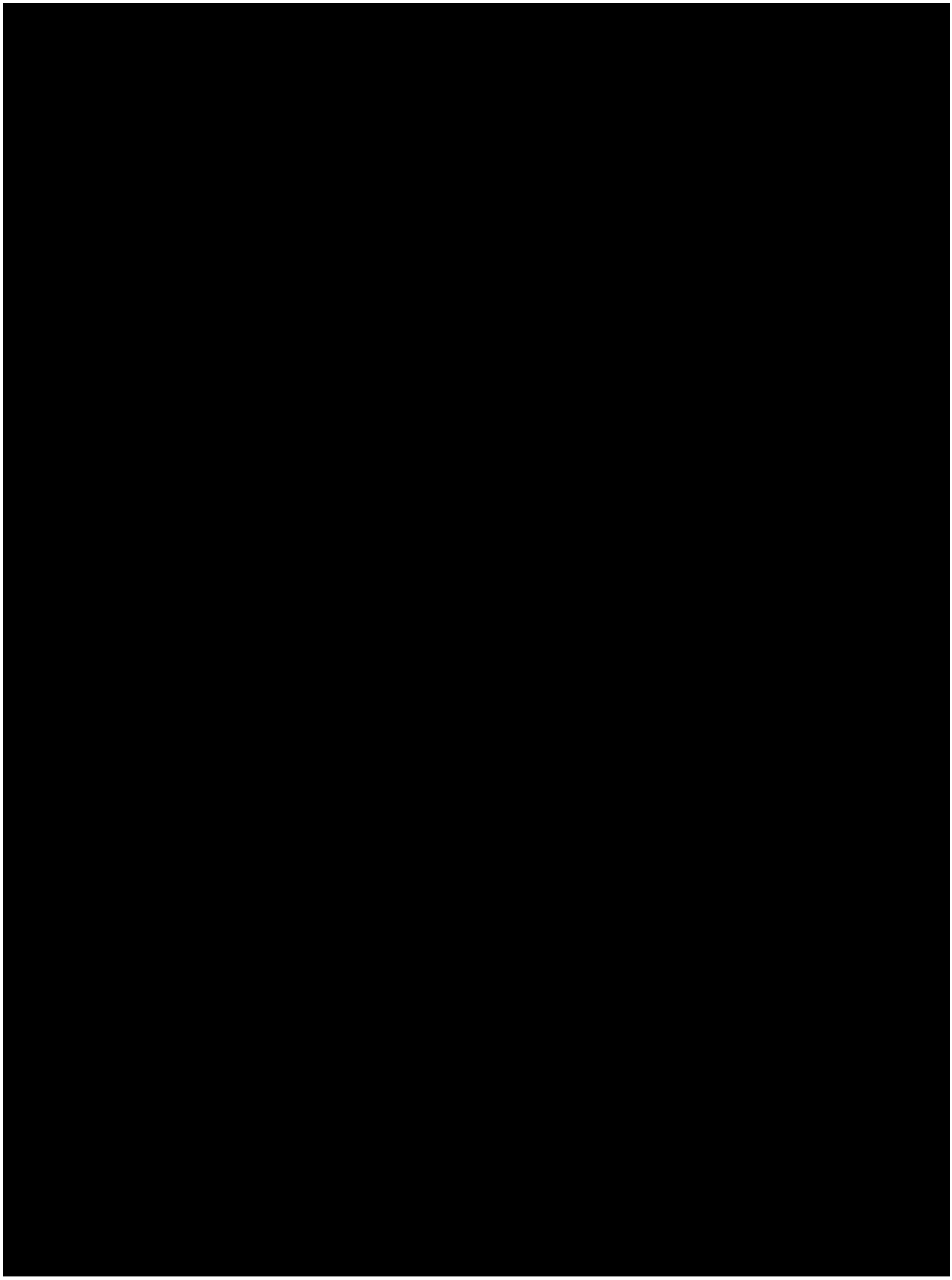
2.6.13 Claims Management

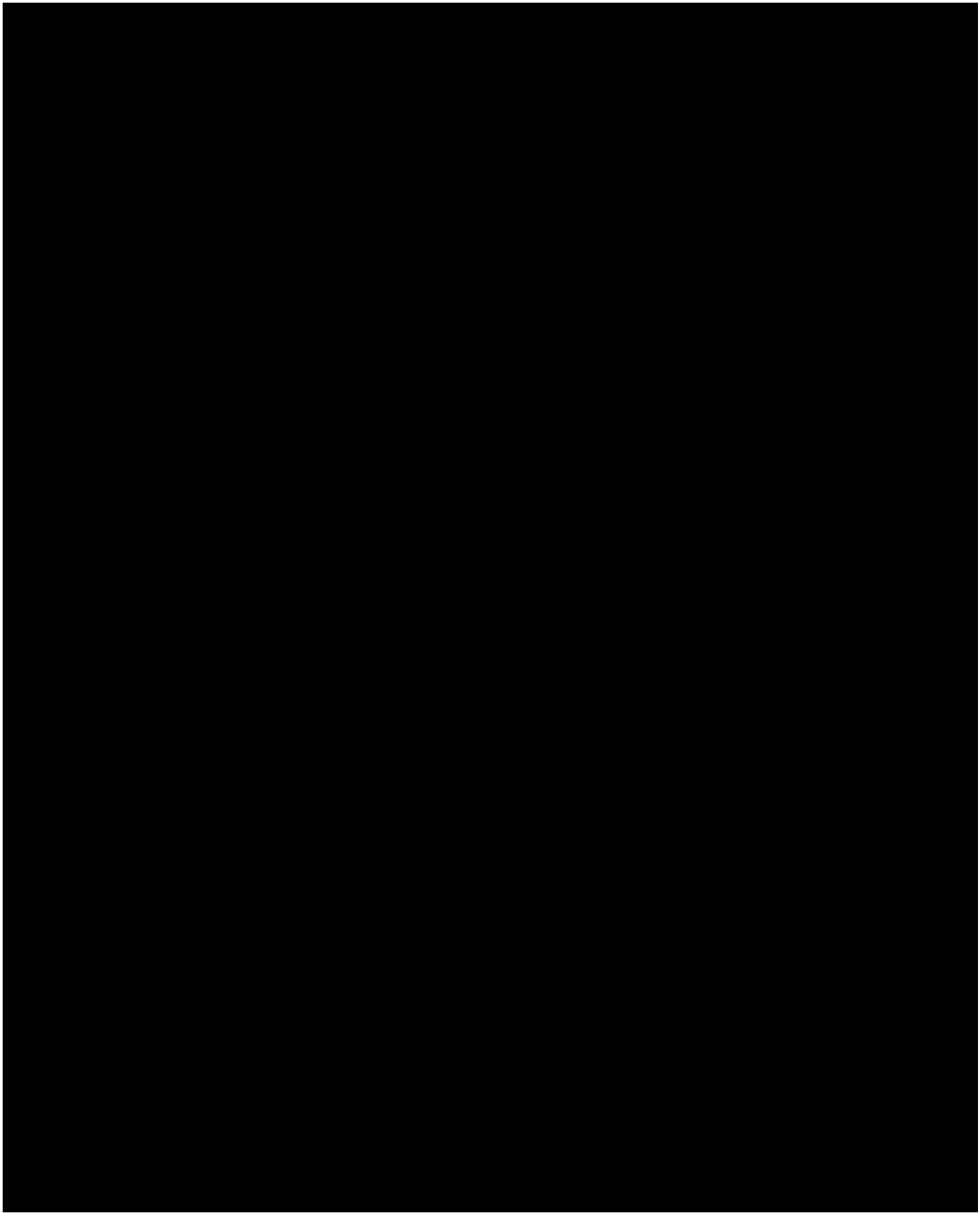
Attachment 2.6.13.1 Claims Adjudication Process
Attachment 2.6.13.2-1 High Level System Architecture
Attachment 2.6.13.2-2 Key System Architecture
Attachment 2.6.13.2-3 IT Data Flow

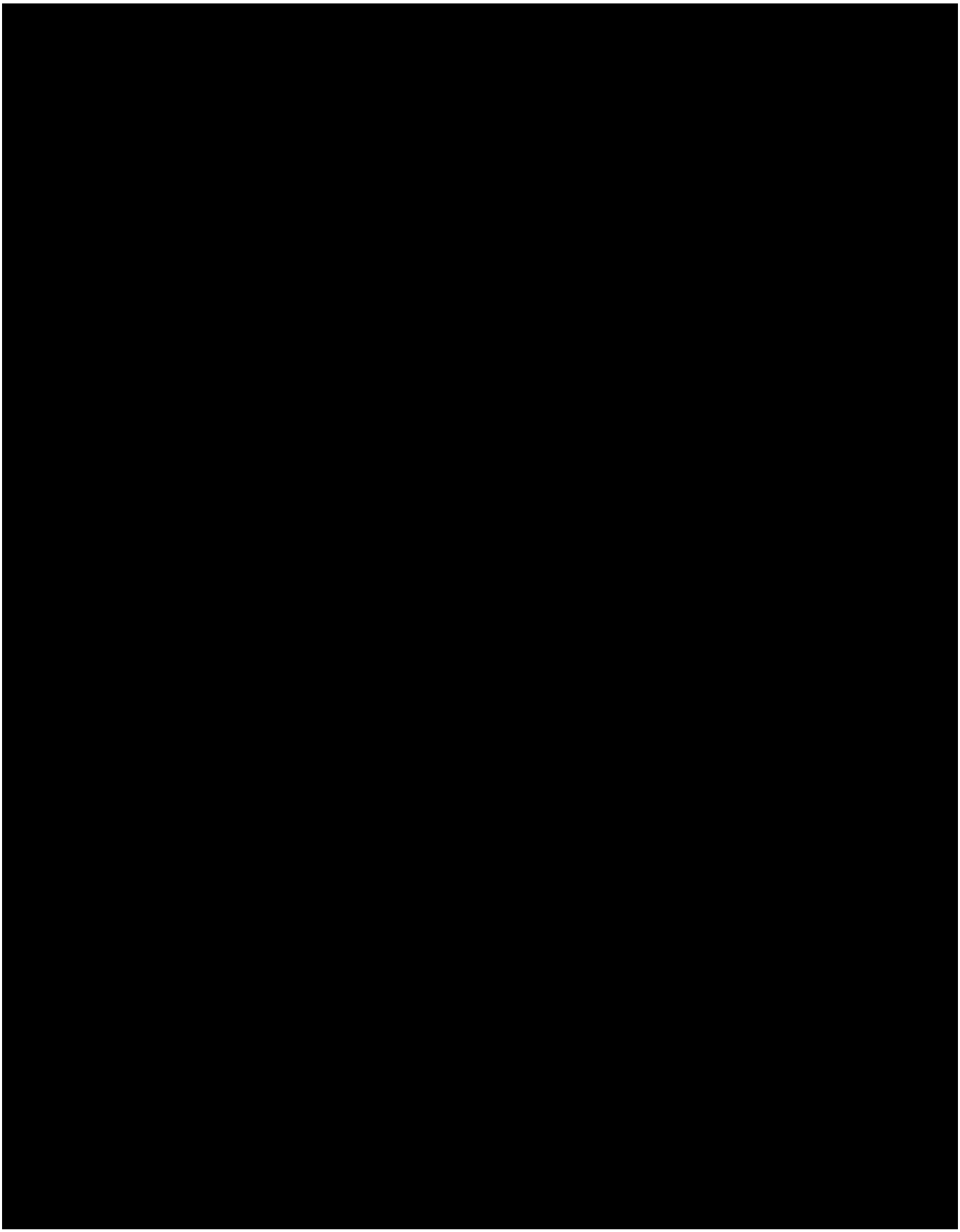


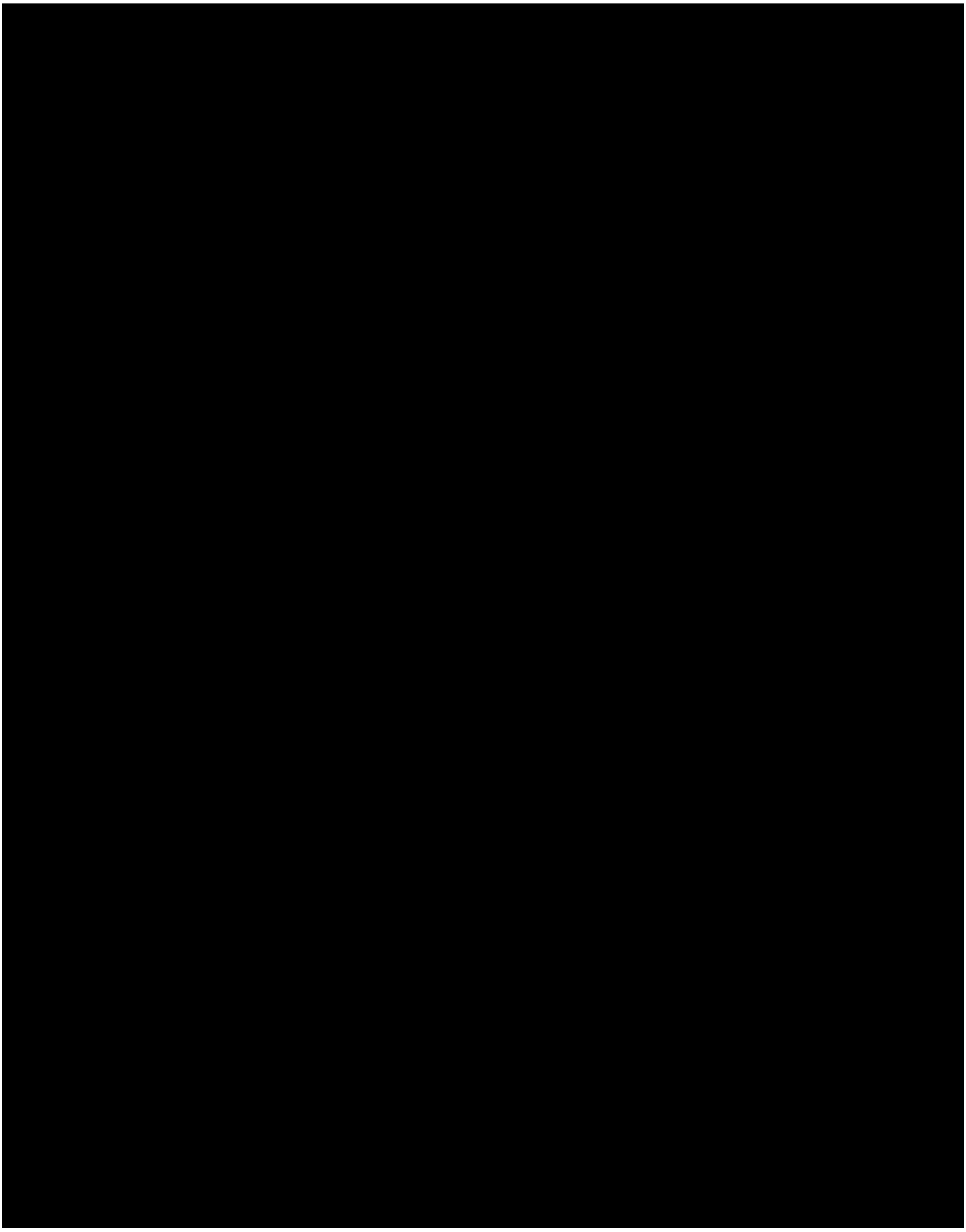


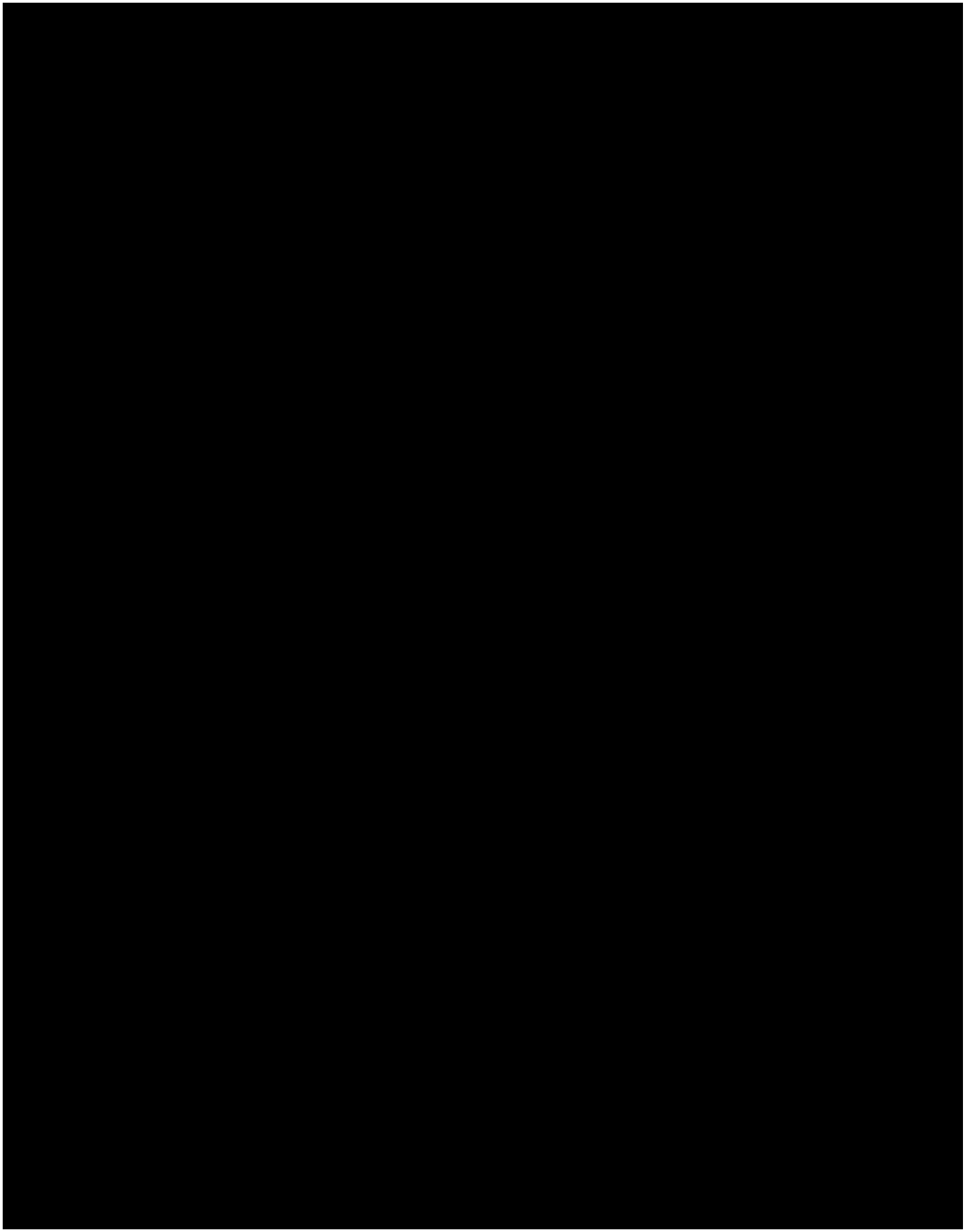


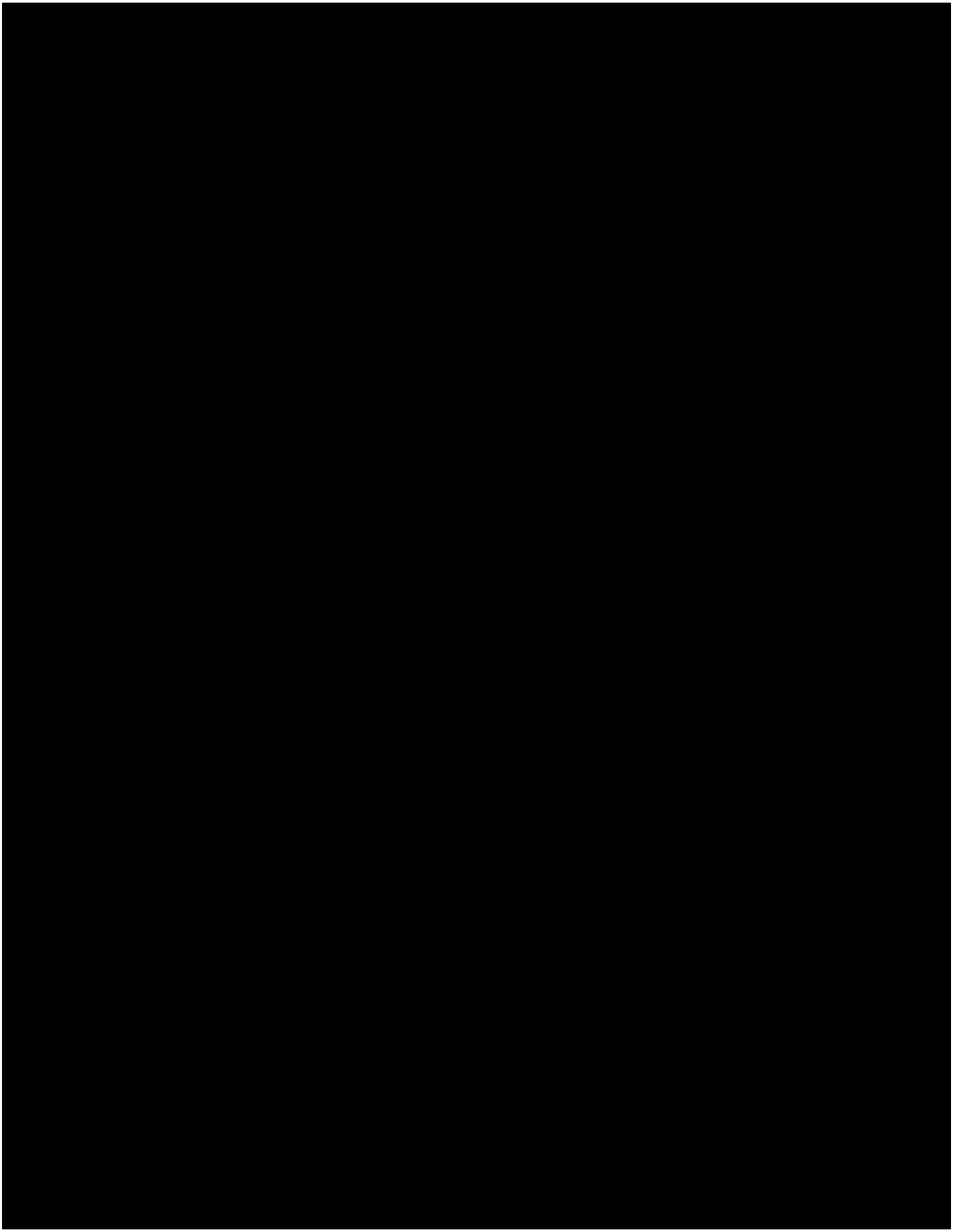


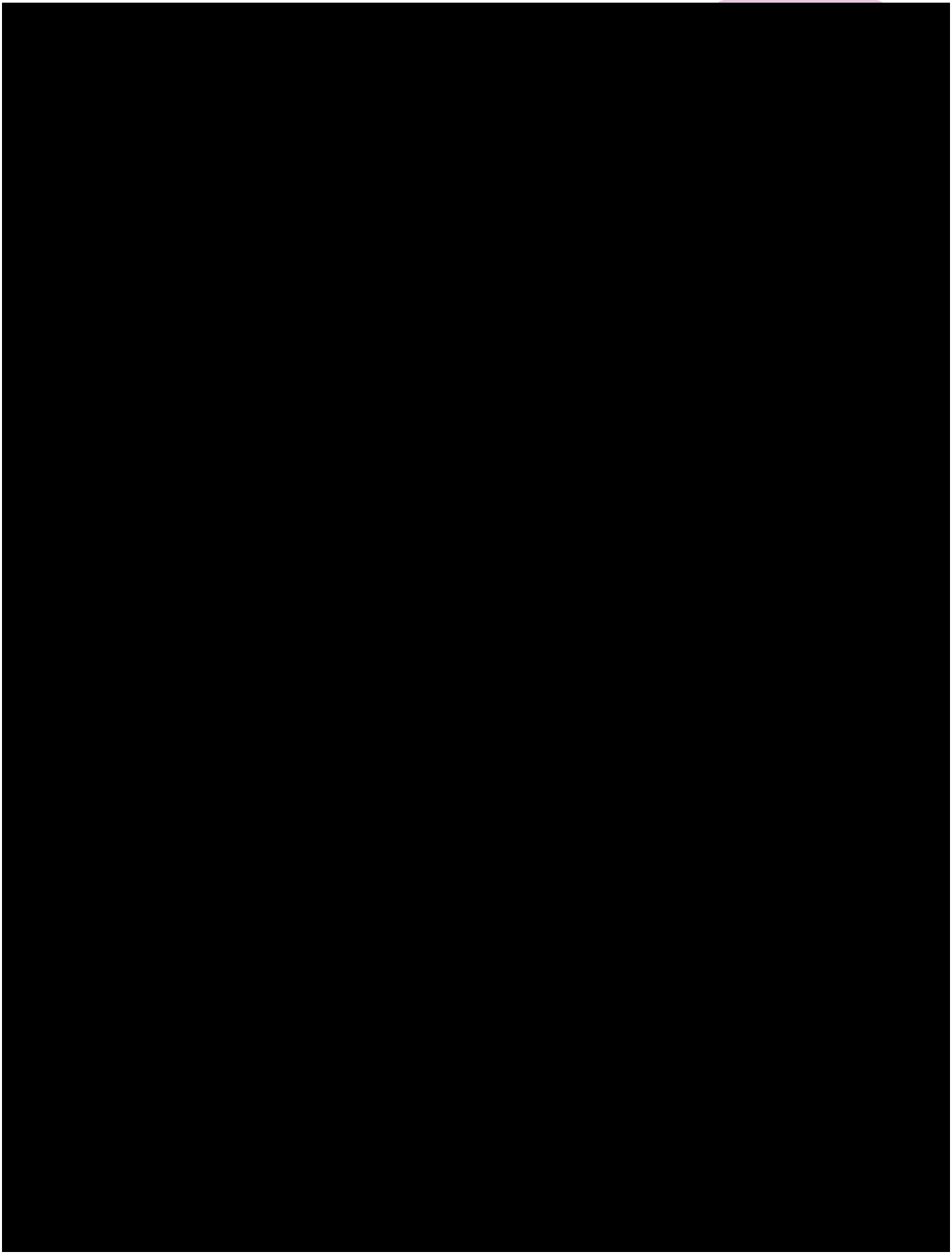


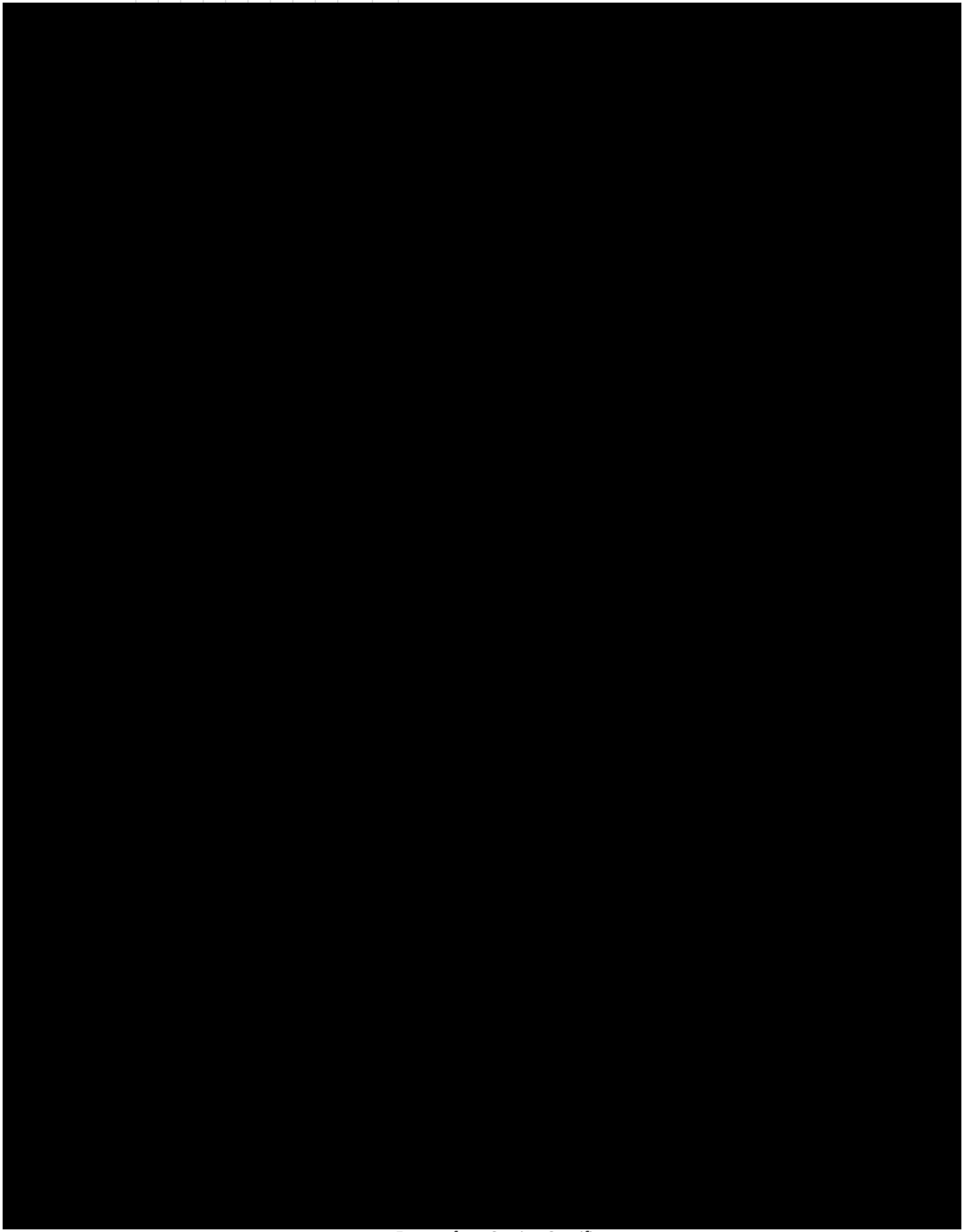


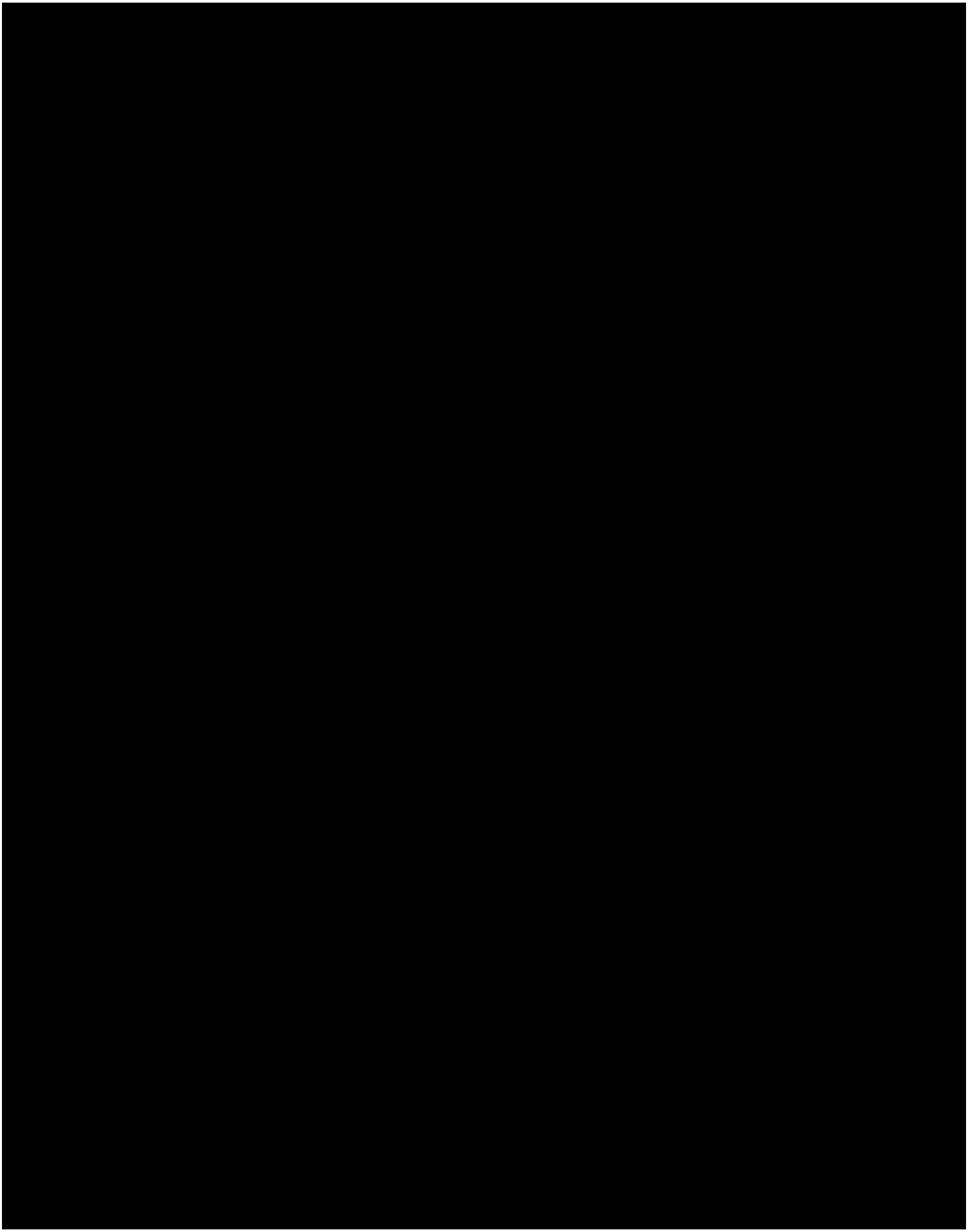


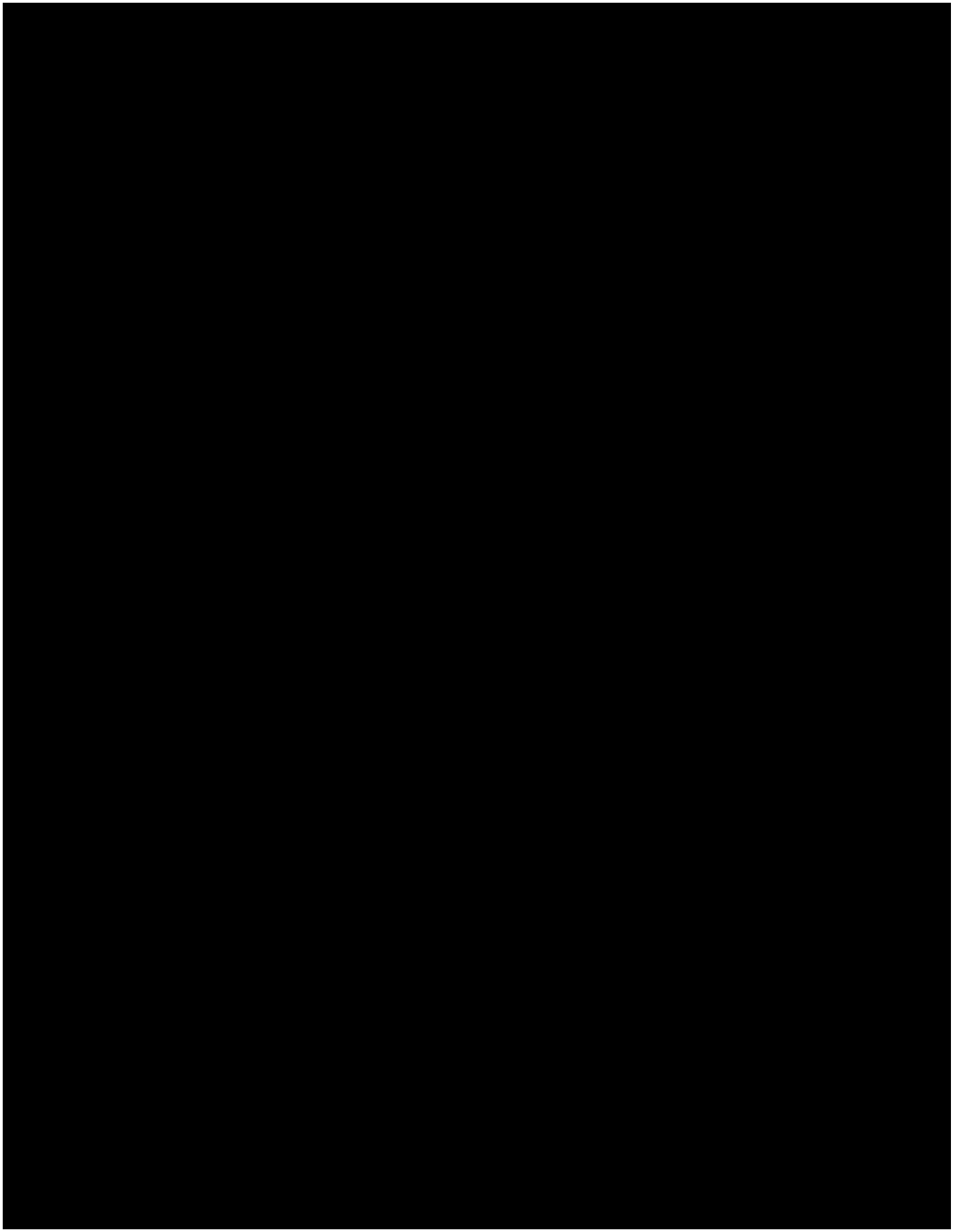


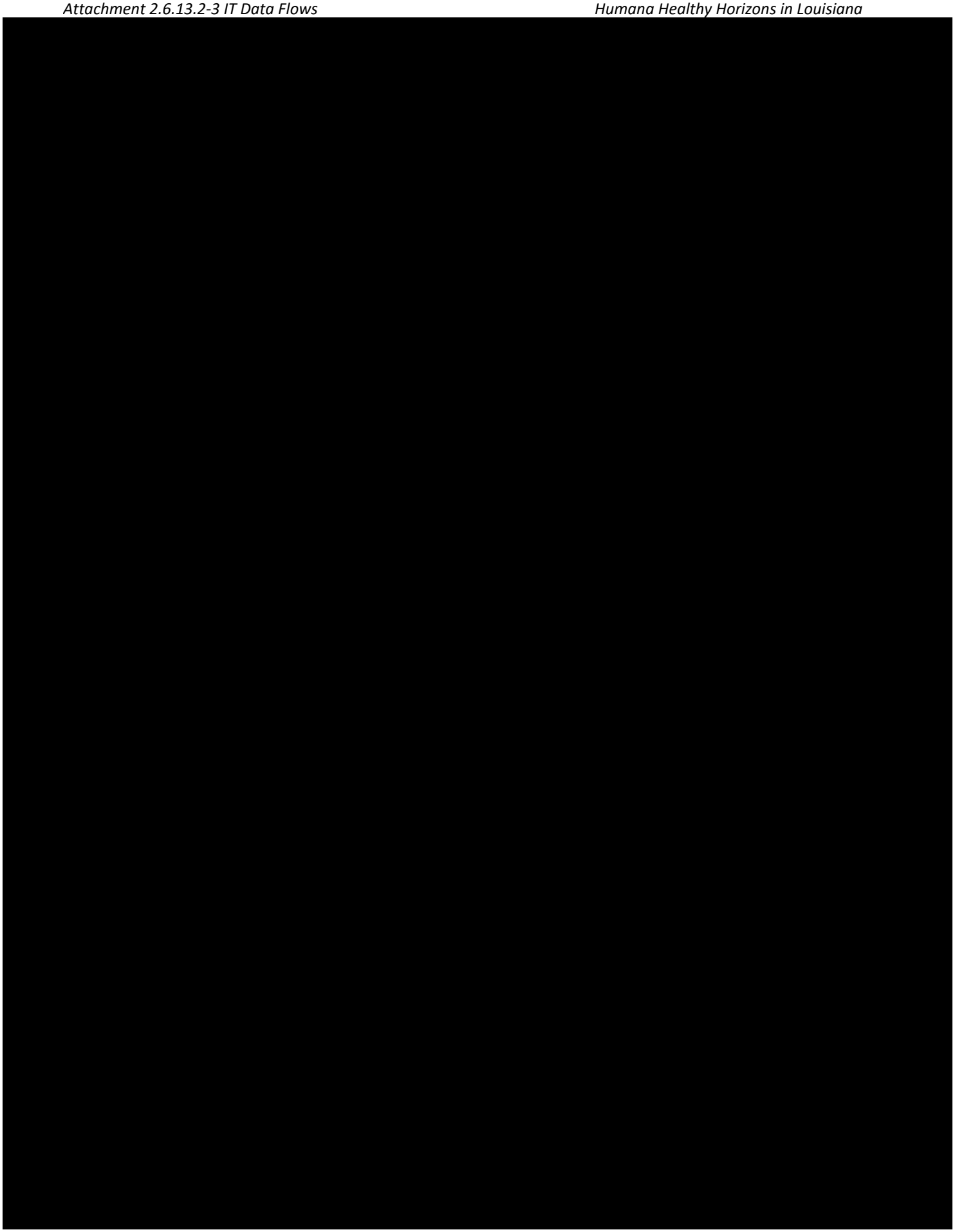


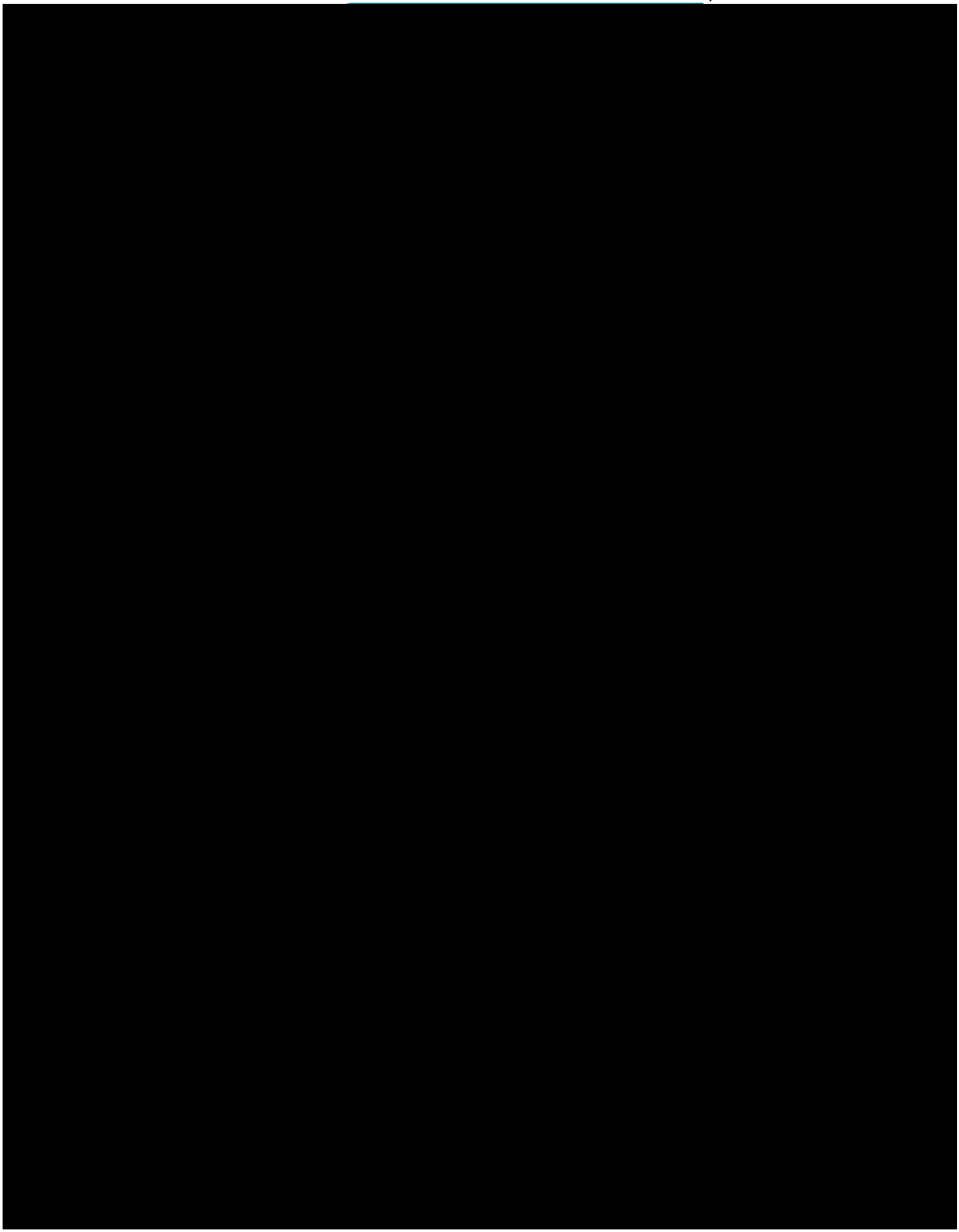


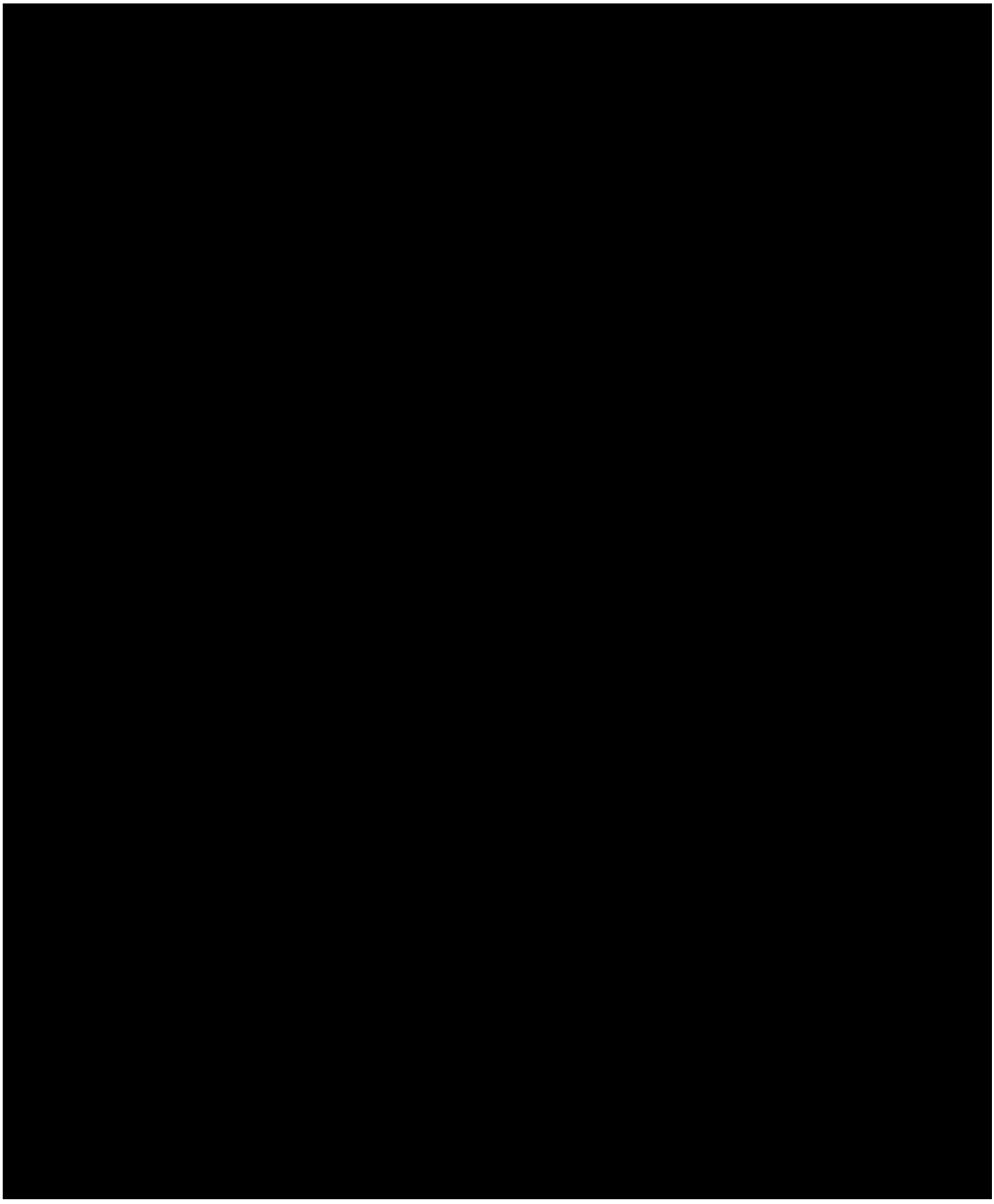












Humana sets up a table at the Makin' Groceries event, July 23, 2021. Associates were on hand to share giveaways and answer questions about the available services. Humana sponsors the Makin' Groceries Mobile Market, improving access to food and essential resources in rural communities across Acadiana.

Section 2.6.14

Program Integrity

Humana

Healthy Horizons™
in Louisiana

2.6.14 2.6.14 Program Integrity

Humana Healthy Horizons in Louisiana has reviewed and confirms adherence to the requirements in **Model Contract Section 2.20**.

Humana has developed a deep understanding and expertise in the investigation of fraud, waste, and abuse (FWA) by participating for over 30 years in publicly financed healthcare programs centered on innovative program integrity activities, resources, and strategies. We view FWA as a company-wide responsibility and staff more than 1,300 associates engaged in the prevention, detection, and mitigation of FWA, including: medical doctors, nurses, coders, data scientists, certified public accountants, and former agents of the Federal Bureau of Investigation (FBI) and U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG). Recognized as a national leader in FWA, Humana is actively involved with multiple national anti-fraud organizations, including the Healthcare Fraud Prevention Partnership (HFPP), of which we are a founding member, and the National Health Care Anti-Fraud Association (NHCAA), where Humana's Corporate Program Integrity Manager, David Posey, is the Co-Chair of the Medicaid Fraud Group. Humana's Corporate Special Investigations Unit (SIU) Director, David Popik, is a current board member and former NHCAA Chairman.

2.6.14.1 Fraud, Waste, and Abuse Program

> In 2019, Humana's extensive FWA program and Program Integrity activities resulted in **$4.9 billion** in savings.

Local Model: Humana has been an integral part of Louisiana healthcare since 1985. We currently manage care for more than 450,000 Medicare, Duals, and prescription drug plan (PDP) and 39,000 commercial enrollees in Louisiana, and currently have FWA associates in our Louisiana office supporting each line of business. Our goal is to be a true partner to the Louisiana Department of Health (LDH), the Louisiana Medicaid Fraud Control Unit (MFCU), the Attorney General's Office, and the DHHS OIG. We are active participants in the Louisiana State Police Insurance Fraud/Auto Theft meetings.

Humana has built its FWA efforts on a local-national structure, with associates—whom we support with additional corporate resources—dedicated solely to issues that arise in Louisiana. In compliance with **Model Contract Section 2.2.2.4.4.7**, Humana Healthy Horizons in Louisiana's [redacted] We have appointed a Louisiana-based [redacted], is a long-time Louisiana resident, and manages the plan's Program Integrity associates, including investigators (an additional one full-time investigator for every 50,000 enrollees). [redacted] will oversee FWA monitoring and enforcement to prevent and detect potential violations and areas of risk. We also have a dedicated a Regulatory Compliance Officer, who will be the primary point of contact for FWA issues and will ensure reports are submitted properly and promptly, as well as monitor any corrective action plans (CAPs).

Continuous Monitoring and Oversight: Led by our Enterprise Risk Management (ERM) associates, Humana employs a structured oversight and monitoring operation program, including committees, based on the Three Lines of Defense model. The model structure applies to organizing oversight, risk management, and internal control roles and responsibilities. By applying the Three Lines of Defense (see **Figure 2.6.14.1-1**), we improve communication and coordination across all areas of risk using a layered support structure of monitoring, oversight, and accountability for both internal and subcontractor activities. The First Line of Defense includes functional area leaders who identify risk within their area of responsibility (e.g., reporting, performance compliance, FWA). Humana uses Enterprise Solution Point (ESP), a governance platform, to document data, research, and comments; track risk; and update remediation activities. Using the Second Line of Defense, Humana's Regulatory Compliance and Third-Party Risk Management teams monitor risk and oversee the risk management process to ensure our framework is consistent across functions (e.g., provider complaints, grievances and appeals, and

program integrity). We use the ESP platform for reporting and tracking as well as issues of noncompliance through CAPs and Issue and Opportunity Plans. Humana's Internal Audit team applies the Third Line of Defense to provide unbiased assurance and independently assess risk. This team conducts independent testing of the design, implementation, and sustainability of the solutions chosen to manage risk, including independent verification of completing CAPs and Issue and Opportunity Plans.

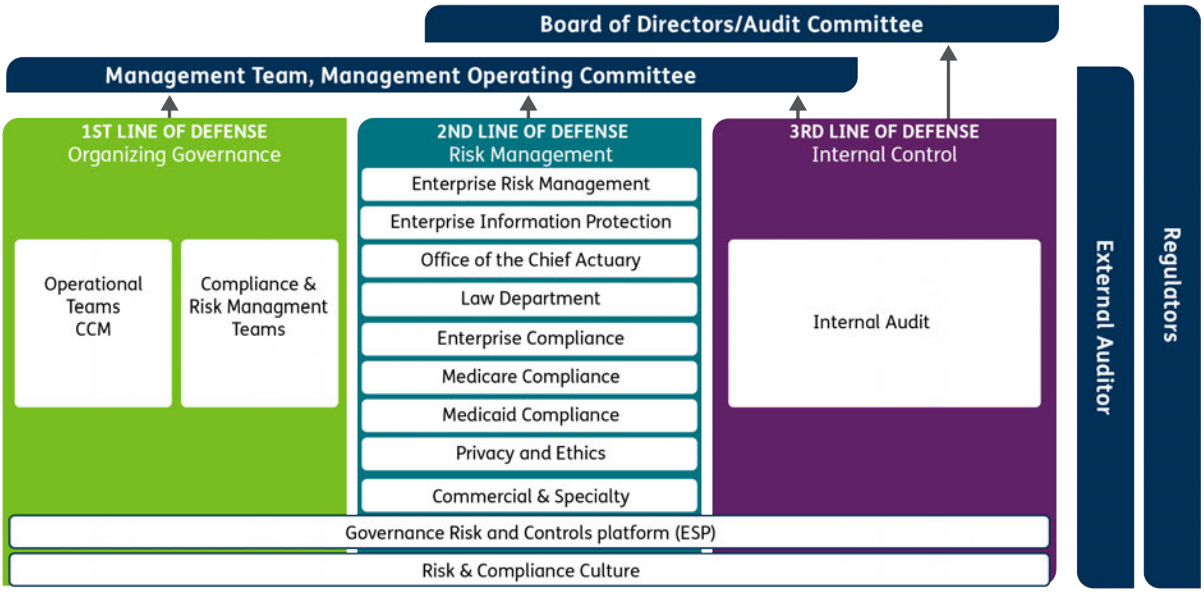


Figure 2.6.14.1-1: Humana uses the Three Lines of Defense model to manage risk.

Addressing Model Contract Requirements on Fraud, Waste, and Abuse

As a key component of our FWA Program, our **Compliance Plan** details our FWA policies and procedures (P&Ps) and incorporates our Anti-Fraud Plan (see **Figure 2.6.14.1-2**). Our Compliance Plan clearly delineates our expectations for our associates and subcontractors. Incorporating the DHHS OIG guidance, we structured our Compliance Plan to adhere to all relevant federal and State requirements, including the **Model Contract** and **Louisiana regulatory requirements**. Along with our Code of Conduct, our Compliance Plan incorporates the **Model Contract, including Section 2.20**, applicable Louisiana laws and regulations, La. R.S. 46:437.1-14, LAC 50:1, and requirements set forth in applicable federal and state anti-fraud laws, regulations and policies, Part 2, 42 C.F.R. Part 438 and Part 455, Part Subpart A, Subpart 5 and 42 U.S.C §1320a-7 1320c-5 and §1396a(a)(68), and specifically describes:

- **Written policies and procedures for investigating FWA** as required by **Model Contract Section 2.20.2.1**
- **Compliance Officers**, Corporate **Compliance Committee,** and local leadership
- Mandatory **training and education** for all associates, providers, and subcontractors

Effective lines of communication, including **a dedicated email address** that we check daily for tips, a **well-publicized Ethics Hotline to** report violations, an Ethics Helpline for assistance and questions, and multiple ways to **report suspected FWA anonymously and confidentially**, as well as and ethics violations, including through our website, call centers, and ethics hotline

- Well-publicized **disciplinary standards** and enforcement mechanisms, including termination
- **Routine monitoring and auditing** to prevent and detect FWA, including service patterns for providers, subcontractors, and enrollees; random claims payment reviews; code and payment edits; and **announced and unannounced site visits and field audits** of providers
- **Prompt response to compliance issues** as defined by our policies and procedures, including **investigations** of suspected FWA, **confidential reporting** as described in **Model Contract Section 2.20.1.11,** and a strict **non-retaliation policy**

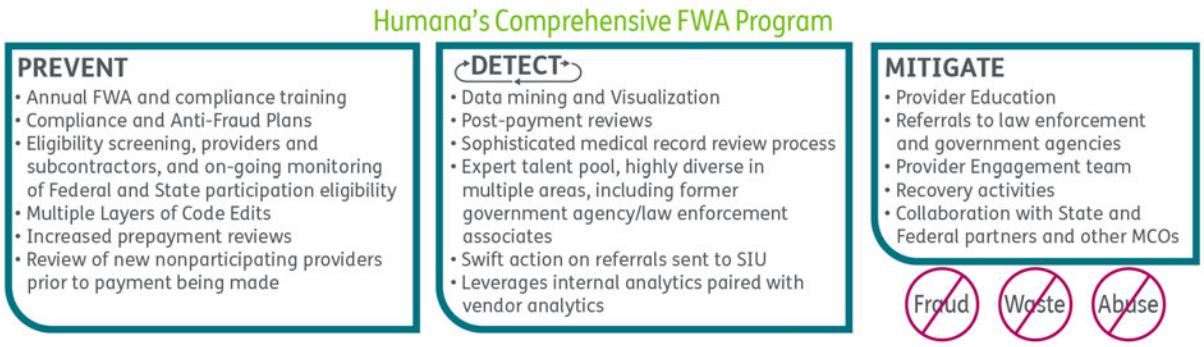


Figure 2.6.14.1-2: Humana's FWA Program centers on prevention, detection, and mitigation.

Along with clear guidance, training, and effective communication channels, our FWA program is based upon advanced analytics and data science capabilities (e.g., artificial intelligence, data robots, machine learning, etc.) that we use to identify opportunities and build processes that evolve as the risks we face evolve. Our FWA program is primarily operated internally by our well-trained, experienced associates who investigate claims payments for both pre- and post-pay. This process leverages proprietary algorithms and vendor relationships that supplement Humana's efforts. **Our three primary areas of focus for program integrity activities include the prevention, detection, and correction of FWA.** Within each focus area, our Claims Cost Management (CCM) team identifies priorities by provider type and the topical area of risk. We identify and develop innovative strategies, update existing protocol, leverage data analytics and algorithms, and identify collaborative efforts. Our CCM department is fully dedicated to FWA and contains shared services teams with cross-functional responsibilities and sub-units with their own niche areas of expertise. **CCM has more than 1,300 associates and invests approximately $120 million annually with vendors (e.g., code edits support, risk evaluation, monitoring targeted pilots, etc.) to identify new FWA opportunities.** Our SIU is a sub-unit of CCM and focuses on fraud investigations while our Provider Payment Integrity (PPI) and Coordination of Benefits (COB) teams focus on waste and abuse. **Special Investigations Unit:** Staffed with more than 130 associates across the country, including in Louisiana, SIU is a sub-unit of CCM and is responsible for fraud investigations. SIU receives referrals from multiple sources. Our Triage team reviews all referrals to ensure only the cases with the highest potential of fraud are assigned to our investigators. The SIU's investigation protocol includes on-site reviews, claims data analysis, medical records and expert reviews, provider/provider staff interviews, law enforcement collaboration, enrollee interviews, and information sharing with appropriate entities. In accordance with the **MCO Manual**, SIU will complete all investigations within 300 calendar days unless LDH requests an extension. Per **Model Contract Section 2.20.1.11.4**, once SIU makes a referral to LDH, we will not contact the subject of the referral until LDH grants permission.

In 2019, the SIU reviewed more than nine million claims, and their work resulted in **$74 million in fraud-related savings.**

Provider Payment Integrity: Our PPI (a sub-unit of CCM) approach for pre- and post-payment reviews is to move as many post-payment reviews to prepayment edits. Total Humana Overpayments Resolution (THOR)**,** the tool used by our PPI team, enables us to aggregate and analyze medical record data, claims information, and internal and external data sources and intelligence to reimburse healthcare providers correctly the first time. THOR is complimented by real-time access to medical records and natural language processing capabilities. This results in a drastic reduction of provider abrasion, including a decrease of 1.25 million in provider letters annually and approximately $50 million in additional annual medical cost savings from avoiding recoupment collectability issues, audit time frame limitations, and additional medical record requests. Our CCM Organizational Chart appears in **Figure 2.6.14.1-3**.

Figure 2.6.14.1-3: Our CCM team shares responsibilities based on expertise.

Additional Key Elements of our FWA Program

Automated Processes and Edits: Our Claims team has built more than 1,000 code edits into our Claims Adjudication System (CAS) to prevent improper payments. Our Claims team regularly analyzes Interest Reports (on unpaid claims) and drill-down reports, by reason and code category, to identify high-risk claims. **For our Medicaid line of business, code edits resulted in more than $890 million in 2019 and more than $790,000,000 in 2020.**

Steps to Reduce Provider Abrasion:
- Establishing a direct live line run by PPI to answer provider recovery questions
- Establishing our Provider Engagement team to do education and training
- Investing substantially in the CCM Issue Resolution team and provider portal to improve self-service, including a Claim Simulator tool

Prepayment and Postpayment Reviews: PPI associates review claims on a routine basis. These reviews focus on provider billing and coding errors, COB issues, retrospective claims reviews, and identification of contracting errors through desk audits and on-site reviews. PPI completes medical record reviews that focus on billing and coding errors, medical necessity reviews, services not rendered, level of care validation, preventable readmission, and clinical diagnosis validation. PPI also leverages its investigative and reporting capabilities to respond to new types of high-risk claims or areas as Humana's business model evolves. **For example, PPI has adjusted its capabilities to address our value-based providers and payment arrangements.** PPI also conducts Value-Shared Payment Integrity Reviews that focus on arrangements where Humana manages contested paid claims from primary care provider (PCP) groups with risk-sharing arrangements. In these instances, overpayment of claims or applying claims to the wrong risk fund could impact the PCP groups' surplus payment. In addition to these reviews and audits, PPI routinely conducts prepayment reviews. Examples of PPI's most common areas of prepayment reviews are: provider billing and coding errors (e.g., excessive charges or selection of wrong codes, which may result in a higher than appropriate payment) and Diagnosis Related Group (DRG) upcoding, lack of documentation to support the services or days billed; services not rendered (e.g., duplicative charges); clinical diagnosis validation (e.g., lack of objective clinical information in the medical record to support the condition for which services were billed); and level of care validation and preventable readmission. **In 2020, our PPI's reviews resulted in Medicaid savings of $26.7 million through our code edits and $53.7 million through our prepay reviews. Our PPI's savings from prepay reviews in 2020 across all lines of business totaled $1.85 billion.**

Postpayment Claim Reviews and Audit Projects: We continuously assess paid claims postpayment to identify over- and under-payments for network and out-of-network providers through desk audits and on-site reviews. Retroactive review may occur after receiving a provider inquiry or additional information from our partners or through automated processes generated when Humana receives updated enrollment and eligibility files. During these reviews, associates examine whether the bill complies with the provider's contract. Our postpay reviews confirm that enrollees received appropriate and cost-effective services and supplies. Other examples include COB, duplication of billed claims, billing and coding errors (experimental or investigational services billed), payment for services that fail to meet professionally recognized standards, retrospective claims reviews (a claim paid in duplicate or error), and items not separately payable or included in another charge (reusable items).

Fraud Response Team: The Fraud Response team comprises senior investigators with highly specialized skill sets, such as experience working at State MFCU, the OIG, and the FBI. The team coordinates weekly with internal and external partners to collaborate and investigate new and trending schemes impacting Medicaid. Their staff works closely with the Fraud Research Analytics and Concepts (FRAC) team to identify and data mine elements to address new and emerging FWA. Their pre- and post-payment activities have resulted in changes to prepayment edits and reviews. This proactive process enables our team to examine medical records to determine medical necessity in genetic testing, mail order pharmacies (e.g., compounds for foot creams), and durable medical equipment (DME) (e.g., back braces). These processes have led to successful referrals to our law enforcement partners using our Fast Track Referral process, implementing additional process controls, and reducing inappropriate payments.

Our Corporate Compliance Plan outlines our extensive training program aimed at educating our associates, providers, and subcontractors about FWA and prevention, ensuring that FWA remains a company-wide responsibility as evidenced by our Three Lines of Defense.

2.6.14.1.1 Training Programs for Employees, Subcontractors, and Providers

Associate Training: Before we extend an offer of employment, we carefully screen prospective associates for eligibility (and continue to screen monthly thereafter) to participate in a federal or state healthcare benefit program in accordance with **Model Contract Section 2.20.3**. Upon hire, we require all Louisiana associates complete and attest to comprehensive training about the Louisiana Medicaid program and Model Contract requirements. We also require mandatory Ethics & Compliance training within first 30 days of employment and annually thereafter that includes FWA topics. This requirement applies to all Humana associates, including the CEO, all senior leaders, and the Board of Directors. The Corporate Learning Center tracks completion of the training and automatically suspends access to Humana systems for anyone who fails to complete the training. Our associate intranet enables easy access to our Ethics and Compliance training, which associates and contractors can use as a resource. Content includes:

- Our comprehensive Code of Conduct and a description of our Compliance and Anti-Fraud Plans
- A description of privacy and FWA laws and requirements (**Model Contract Section 2.20.2.2.4**)
- Information on how associates can report suspected cases of FWA
- Whistleblower protections for anyone who reports FWA

We have additional specialized training for CCM/SIU associates. **For example, our SIU has extensive two-phase training designed to specifically address SIU's functions, processes, and applicable requirements, and SIU associates are required to complete 20 hours of specialized training annually**. Supplemental training by SIU is also available upon departmental request. Along with our structured annual training, we use several methods to provide information and training throughout the year. For example, we update our intranet home page daily to include topics related to FWA and compliance. Associates also receive emails highlighting specific topics and updates.

Subcontractor Training: We apply the same requirements to our subcontractors, and many require additional training for their employees. The first step we take to establish a relationship is to carefully screen subcontractors and ensure they have not been suspended, excluded, or debarred from participation in a federal or Louisiana program. **We repeat these checks monthly** to uncover any changes to a subcontractor's eligibility. Next, subcontractors must complete the required training within 30 days and annually thereafter, or we terminate their access to Humana's systems. Many subcontractors also complete specialized training related to their specific functions and are often subject to additional internal training topics in alignment with our Humana associates. Subcontractors also receive supplemental training by our SIU/CCM upon request.

Provider Training: As with associates and subcontractors, our first step in FWA prevention is to screen providers for eligibility to participate in federal and state health care benefit programs, which we repeat monthly thereafter. We conduct training for those screened providers on FWA in three phases: an initial mandatory training during our provider orientation, annual refresher training, and ongoing training in coordination with our Provider Relations team. The initial training is required within 30 days of inclusion in our provider network and includes comprehensive training on our Code of Conduct, our Compliance and Anti-Fraud plans, FWA, laws and regulations, reporting requirements, whistleblower protections, and specific Louisiana Medicaid requirements. We also include information about FWA and how to report it in our provider handbook, through our provider portal, and in our provider training manual. Along with mandatory annual refresher FWA training that Humana or the provider's office conducts, our CCM or Provider Relations associates conduct additional training when:

- There are changes in Medicaid, FWA, or Humana policies, procedures, or requirements
- Data analytics identify a trend/opportunity for correction across all providers or a subset of providers (e.g., BH providers, laboratories, etc.)
- The Provider Resolution associates identify a trend or opportunity for correction

2.14.1.2 Engaging Enrollees in Preventing FWA

Humana has an ongoing, comprehensive, enterprise-wide Member Awareness Campaign aimed at educating enrollees about all types of fraud, including FWA, identify theft, and financial scams. We have an extensive public website that describes common FWA schemes, as well as other types of fraud typically aimed at enrollees such a COVID-19 schemes and other topic-specific engagement (e.g., lab tests, foot baths, DME, etc.) to educate enrollees on how to protect themselves and identify FWA. We inform enrollees about resources through our member materials, including our Smart Summaries, which are similar to explanation of benefits (EOBs) for Medicaid enrollees, and via our enrollee handbook.

In addition, we engage enrollees to prevent FWA by specifically incorporating them into our Anti-Fraud Plan and targeting education through various channels. Along with our Enrollee Handbook's information about FWA prevention and reporting, our website prominently features information about FWA and how to contact Humana to report a suspected violation. In accordance with **Model Contract Section 2.18.11**, our SIU specialists use our data warehouse to randomly select enrollees who receive Smart Summaries verifying the service and ensuring the sample is stratified so all provider and claim types are represented in accordance with **Model Contract Section 2.18.11.2**. We include directions on how they can contact Humana to report discrepancies, and Enrollee Services Representatives contact the enrollee to confirm they received the letter, verify the service, and report discrepancies within three business days.

Case Example

During a review of DME services in Louisiana, an enrollee told an SIU Investigator that he did not order the shoulder or wrist orthosis he had received from a DME provider. The investigator learned that the enrollee had also received braces he did not request from the same provider. Following this call, SIU quickly placed the provider on prepayment review so 100% of claims were denied because the medical records did not contain an objective assessment to support the orders. This resulted in significant savings and we made the appropriate government referrals.

For enrollees who want to contact us for information, provide a tip, or report a suspected violation, we have a dedicated email address checked daily dedicated toll-free hotline. Our Enrollee Services Representatives will also take these calls, and our interactive voice response is configured to support enrollee tips. This information is available in our Enrollee Handbook and on our website.

2.6.14.1.3 Data Analytic Algorithms for FWA Prevention and Detection

Our FWA prevention and detection techniques leverage sophisticated statistical analysis to detect anomalies and outliers. **The FRAC team runs daily algorithms that flag more than 12,000 data files and utilizes more than 300 dashboards to identify questionable or suspicious claims for further review to prevent erroneous transactions** and **inappropriate payment**. As FWA continues to evolve, our team modifies our efforts while adopting innovations, shown in **Table 2.6.14.1.**, including Machine Learning and artificial intelligence (AI) and Natural Language Processing (NLP), which increases efficiency in FWA identification processes.

Table 2.6.14.1.: Data Analytic Algorithms for FWA Prevention and Detection

Algorithm	Description
Data Analytics and Predictive Modeling	FRAC and Overpayment Solutions and Opportunities (OSO) use state-of-the-art software applications such as Power business intelligence (BI) and Tableau dashboards to construct analytical, statistical, and predictive models that identify and detect FWA. Our methodologies include **outlier and link analysis, rules-based anomaly detection, trend analysis, and statistical analysis**. We focus these models on specialty or service types we consider high-risk as defined by our risk framework and cross-collaboration with compliance and risk teams. FRAC selects data based upon detailed investigation and research into potential fraud schemes and analysis to identify data markers that potentially indicate FWA. CCM's top audits primarily focus on billing and coding errors, COB issues, contracting updates and issues, drug utilization, and validation.
Value-Based Payment Monitoring	The Risk Adjustment Integrity Unit (RAIU) is responsible for investigating instances of FWA in Humana's provider network that impact risk adjustment submissions. RAIU does data analysis of provider behavior to identify outliers indicating potential fraud (e.g., analysis by condition or diagnosis compared to diagnostic tests, pharmacy usage, or DME). RAIU also conducts focused risk adjustment investigations and fraud detection analysis for value-based providers. Expertise in this area is essential to ensuring proper review of paid claims and subsequent risk-sharing payments.
Machine Learning and Artificial Intelligence (AI)	Machine learning and AI technology enable CCM to identify FWA sooner in the process. For example, DataRobot helps identify the best model for a use case and streamlines model implementation. Clinical Language for Inventory Prediction Prioritization reduces manual work and reprioritizes medical records to review impactful records sooner in the process.
Natural Language Processing (NLP)	A form of AI, NLP enables our system to read and analyze large amounts of data in medical records (e.g., phone calls, provider notes, charts) and interpret it in a structured manner. NLP integration drastically reduces the time per review by identifying records most likely to have overpayment opportunity and summarizes the information, pointing the reviewer to the specific pages where desired information is located to confirm overpayments. **Humana invests nearly $3 million annually in NLP capabilities, with nearly 90 areas using or developing NLP capabilities**.
Prepayment Claim Edits	Prior to payment, our CAS finds claims with inconsistent data such as type code, group number, or contracted provider number, and flags the claim as requiring manual processing.
Provider Profiling	FRAC has built proprietary models to analyze provider behavior and identify outliers. FRAC's analysis uses variables such as specialty, geography, claims history, and other groupings. FRAC can stratify providers' FWA risk levels and identify those in the high-risk category.
Cyber Threats	Because fraud increasingly includes a cyber component, our algorithms focus on cyber threats, including ransom attacks. A multidisciplinary team completes a threat assessment every other day and circulates our Cyber Threat Assessment Report that indicates the level of risk detected (i.e., red, yellow, green). Cyber Hunting Analytics Response Team (CHART) conducts vector assessments of incursions and builds threat profiles and day-to-day threat assessments. FRAC and CHART identify high-risk outliers for each of their teams to build into their algorithms that include protected or confidential Information, including anything that impacts enrollee protected health information, provider information, or provider intellectual property, foreign involvement or ownership in provider organizations, and header data (i.e., certain indicators in the headers of software data that indicate fraud).
Pharmacy	FRAC's dedicated pharmacy associates proactively detect pharmacy related FWA through a suite of proprietary tools and algorithms to identify inappropriate medication usage, including detection of potential risk areas such as overutilization or suspicious prescribing patterns. For example, we use opioid predictive modeling with machine learning to identify high-risk members with precise

Algorithm	Description
	measurement. Our Drug Utilization Review (DUR) program assesses both drug use in individual enrollees and prescribing and dispensing patterns among providers and pharmacies. The DUR process, which is both prospective and retrospective, reviews claims and other electronic data to identify over- and under-utilization, contraindications, therapeutic duplication, and misuse of controlled substances.
Electronic Visit Verification	SIU uses Electronic Visit Verification (EVV) to verify services such as home visits, along with the services provided during those visits, to safeguard against inappropriate billing and FWA.

2.6.14.1.4 Methods to Identify High Risk Claims

Our approach to identifying high-risk claims continues to evolve as the nature of FWA changes. Along with the numerous algorithms and processes previously described, advanced analytics form the foundation of our identification of high-risk claims. **Our expert Fraud Response team's mission is to proactively identify new and emerging areas of risk using data and analytics**. The Fraud Response team coordinates on a weekly basis with both internal and external partners to collaborate and efficiently investigate new and trending schemes impacting all lines of business, including Medicaid. Specifically, the team works closely with the FRAC team to identify and mine data elements to create new processes to address new and emerging areas of risk.

FRAC also plays a critical role by identifying unusual billing patterns, fraud schemes, and complex connections, as well as global scaling of known schemes to identify fraudulent behavior. CCM and its sub-units, including PPI and SIU, also use information such as fraud alerts, CMS and OIG communications and reports, state requests or identification, and information about patterns and trends to identify areas of risk that they then incorporate into our data algorithms, reviews, and audits. We have also identified specific geographic areas or regions within a state as high risk based on patterns and trends in cases or claims. If an area is identified, CCM associates will flag providers in those geographic areas for additional review. Our Claims team works in tandem with CCM and its sub-units using our automated processes and edits, reviews, and audits to identify high-risk claims.

Dedicated Teams for Specialized Functions: Our experience with specific risks associated with particular Medicaid services or types of providers led us to develop dedicated teams who follow targeted procedures for monitoring providers and subcontractors. For example, we have specialized focus in areas such as behavioral health (BH), pharmacy services, and transportation. The Pharmacy Fraud, Waste, and Abuse & Prevention team monitors and audits the pharmacy network to prevent FWA and refers cases of suspected fraud to SIU for investigation. **Across Humana, we conduct a minimum of 5,000 pharmacy desktop audits annually**. We also have specialized teams that focus on COVID-19-related schemes and a Genetics Team that includes more than 10 genetics counselors, nurses, coders, and data analysts to identify new schemes in this high risk area (e.g., medically unnecessary testing, testing not ordered by a provider). In 2019, our genetics-related work resulted in **more than $41 million in savings.**

Identifying High-Risk Claims: Nonparticipating Providers

As a result of the Fraud Response Team's work, Humana utilizes a new proactive process (Nonparticipating Provider Verification Process) to identify new nonparticipating providers believed to be phantom. For example, this team identifies out-of-network providers who were out of state, with addresses outside the U.S., who use the same P.O. Box for multiple businesses or are located in a storefront (e.g., a UPS retail store) that is at higher risk. In Louisiana, this process identified several nonparticipating, out-of-state providers that attempted to bill for DME (i.e., back, wrist, and arm braces) that our SIU determined were suspicious. Following triage and investigation, our SIU referred several cases to the State and placed the providers involved on our internal watchlist.

Defining High-Risk Claims

Our **definition of high-risk claims** changes as the types of risk and fraud schemes evolve. At its core, our definition of a high-risk claim is a claim that does not follow an expected pattern. Our algorithms are designed to identify claims that have the most probability of error and/or to identify an outlier. We have

built processes and procedures to detect changing or emerging areas of fraud and keep apprised of the definitions used by CMS, OIG, LDH, Office of Attorney General, MFCU, the National Health Care Anti-Fraud Association, and other industry leaders. Our Three Lines of Defense model establishes a multilayer oversight structure of continuous monitoring.

2.6.14.1.5 Experience with Provider Recovery Collections

Humana's provider recovery collection approach aims to strike the appropriate balance between minimizing provider abrasion with the recovery process while being good stewards of State Medicaid funds. We work to reduce friction with providers through THOR, our initiative aimed to reduce the need for postpayment recoveries by moving postpayment rules to prepayment edits when possible. Our Provider Relations Representatives and our Provider Engagement team collaborate with providers to identify trends and opportunities to reduce the need for recoveries.

PPI routinely assesses paid claims postpayment to identify overpayments on all paid claims when our algorithms indicate a high error rate or outlier. Retroactive review may occur after receiving a provider inquiry, additional information from our partners, or through automated processes generated when Humana receives updated enrollment and eligibility files. PPI runs monthly queries on all paid claims to identify claims that are likely to be overpaid and to capture any retroactive changes to enrollment or provider contract changes and reviews claims for appropriate payment. PPI tracks recoveries through our Financial Recovery System. In accordance with **Model Contract Section 2.18.13**, we contact the provider in writing, notifying the provider of the details of the claim and how a provider may submit a response. We also notify providers of how to access our Claims Dispute system, including access to independent review/binding arbitration. In compliance with **Model Contract Section 2.20.2.2.15** and the **MCO Manual,** we will notify LDH of all overpayments using the reporting template and subsequently adjust encounters. In accordance with **Model Contract Section 2.18.13.9,** our process prevents recovery from an automated review for a claim for which an automated denial was reversed. **In our experience, an average of 3% of Medicaid claims result in overpayments with an average of nearly $60 million Medicaid postpayment collections annually.**

With over 17 years of Medicaid managed care experience, Humana's associates have deep knowledge in identifying and managing potential third-party liability (TPL) and COB to ensure the state Medicaid program is the payer of last resort. Humana's TPL program builds on our extensive knowledge and experience determining the liability of third parties such as Medicare, liability insurance carriers, and workers' compensation for services rendered to enrollees. In accordance with our TPL program, we cooperate extensively with our state partners and their cost-recovery efforts in our existing Medicaid managed care contracts. The Subrogation and COB teams are sub-units of CCM and administer our TPL program. Our approach to subrogation couples a highly competent internal staff with the specific expertise of outside vendors to maximize our opportunities for identification. In accordance with **Model Contract Section 4.14,** we will not perform TPL for providers with claims over ten months, except in cases of Medicare, TRICARE, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and will obtain LDH's approval for accident settlements over $25,000.

2.6.14.2 Humana's Detailed Description to Produce Required Reports

Humana has produced regulatory reports for publicly financed health care programs such as Medicare and Medicaid for more than three decades. As these reporting obligations evolve, we modify our systems accordingly. For example, as reporting requirements became more detailed and we added additional programs and markets, CCM created a new team, the Compliance Team, to ensure we fulfill these obligations appropriately. CCM's Compliance Team works in conjunction with our SIU and PPI to complete reporting requests. Once the reports are complete, the Program Integrity Officer and Contract Compliance Officer collaborate with the CCM Compliance team to complete quality assurance reviews of the reports to check for accuracy and quality of the information included.

Currently, the CCM Compliance Team produces similar reports for several other state Medicaid agencies as well as numerous other reporting agencies, including CMS. In addition to these compliance reports, multiple states require reports regarding whether tips are substantiated. In accordance with **Model Contract 2.20.1.11**, our SIU will report all confirmed and suspected provider fraud and abuse to LDH and MFCU. The CCM Compliance team uses a tracking system that displays all reports and deliverables with due dates and assigned owners and includes a process for back-up coverage for associate absences to ensure we complete reports and referrals on time and accurately. **Specifically, the CCM Compliance team submitted 238 FWA-related Medicaid reports including monthly, quarterly, and annual reports, to government agencies in 2020. The team submitted 100% of these reports on time.**

Innovations for Reporting Data Related to Program Integrity

Humana has long taken a leadership role in partnering with our state partners to adjust existing reports and develop new reports to account for new types and sources of available data, to identify changes in FWA threats, and to improve the usefulness of the reports for the state. This ensures our understanding of the data sought as well as ensure open lines of communication for process improvements. Specifically, we collaborate extensively with LDH as they reviewed their reporting requirements and identified areas for improvement. **Table 2.6.14.2** shows suggestions for LDH to consider.

Table 2.6.14.2: Innovations for Reporting Data Related to Program Integrity

Innovation	Description
Cybersecurity Workgroup	Recent events have demonstrated that cybersecurity is a critical element of program integrity and Humana has taken a leadership role in this area. Cyber incursions can have devastating consequences and working quickly and across programs and business areas is essential to prevention, detection, and mitigation. Our ERM and CCM—including SIU, cybersecurity, and information technology teams—collaborate extensively with data information sharing and reporting with support from national experts such as Mitre and national organizations such as HFPP and NHCAA to leverage participants' experience. Given the strengths of this model, we will lead a workgroup and collaborate with data representatives from other MCOs and help LDH understand what data all MCOs receive, the controls used, and how LDH can use it best to benefit them and the other MCOs' experiences.
Prevented Loss Report	Receiving a report about prevented loss would provide LDH a more complete picture of MCOs' program integrity efforts. NHCAA's national standards on prevented loss, which are similar to Humana's current process, can be used to forecast 12-month savings. The forecasting process allows for analysis of the impact of events that may have changed behavior (e.g., education campaign, analytics and algorithms, termination, etc.) and should be replicated.
Nonparticipating Provider Report	Our experience has taught us that claims from nonparticipating providers may create a higher level of risk, particularly as they have not been credentialed by Humana or LDH. Our process requires that nonparticipating provider claims are pended as we do a background check to ensure the integrity of the provider and claim. We recommend MCOs report this information to LDH for its own use and so it can be shared across MCOs to prevent further provider activity.
Prepayment Time Frame Report	Monitoring the time frame it takes for MCOs to complete prepayment reviews and make referrals to the LDH upon completion (if applicable) may result in increased savings for LDH. Feedback from our state partners in other markets has been that the quality of our referrals is high as compared to our competitors due to the level of detailed information. Benchmarking and determining an appropriate time frame, coupled with LDH's Referral Form, could result in increased savings to LDH by avoiding inappropriate costs.

Humana has a strong commitment to improving the health and well-being of our enrollees and the residents of the communities we serve, including Baton Rouge, Louisiana, where Humana recently participated in a special cook-off event at HOPE Ministries of Baton Rouge.

Section 2.6.15

Physical & Specialized Behavioral Health Integration Requirements

Humana

Healthy Horizons™ in Louisiana

2.6.15 2.6.15 Physical and Specialized Behavioral Health Integration Requirements

Humana Healthy Horizons in Louisiana confirms adherence to the physical and specialized behavioral health (BH) integration requirements in the **Model Contract. Our person-centered Empowered Care Plus (Empowered Care+) care model addresses enrollees' physical health, specialized BH, medication needs, and social determinants of health (SDOH) needs**. This model aligns with the principles of integration defined by the Louisiana Department of Health (LDH) and the Office of Behavioral Health (OBH) to support enrollees recovering from mental illness/addiction and address whole-person health.

2.6.15.1 Humana Healthy Horizon's Fully Integrated Care Model

Our fully integrated Empowered Care+ care model guides the enrollee on their recovery journey by placing them at the center of the decision-making process as their Case Manager and interdisciplinary care team (ICT) help them navigate physical, BH, and SDOH services. Our Medicare partnership with the Baton Rouge Clinic exemplifies the success of this model, which co-locates BH specialists from the Capital Area Human Services District (CAHSD) at the clinic with primary care providers (PCPs) to provide fully integrated care powered by Humana's incentives and supported by SDOH referrals and data-driven enrollee insights to produce better outcomes and whole-person care. **This program resulted in a 60% decrease of inpatient utilization, 25% decrease in emergency department (ED) utilization, and 17% decrease in outpatient utilization**. Humana's Healthy Horizons in Louisiana's Care Management team, led by [redacted].

Empowered Care+ Care Model: We traveled across Louisiana to learn firsthand about the major issues facing the Human Service Districts/Authorities (HSD/HSAs), federally qualified health centers (FQHCs), rural health clinics (RHCs), and community mental health centers (CMHCs). **We heard consistent stories—the need for increased BH access and coordinated care; support to address trauma, housing, and food insecurity; and a consistent approach for the justice-involved and school-aged children.** Living in the parishes they serve, our Comprehensive Care Management (CCM) team members are on the front lines addressing these issues and making Empowered Care+ a reality. As depicted in **Figure 2.6.15.1-1**, by partnering with the enrollees, families and caregivers, local providers, and community-based organizations (CBOs), we build a community-based approach to integrated care to support whole-person needs and goals.

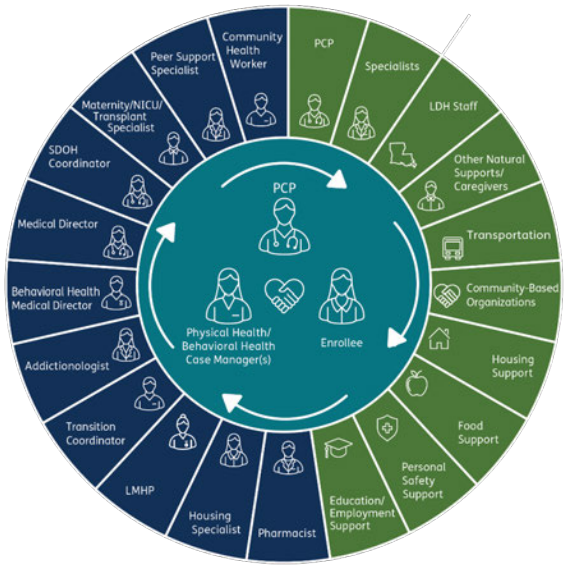


Figure 2.6.15.1-1: Our Empowered Care+ Model addresses our whole-person approach to our enrollee's integrated needs.

Case Managers maintain the individualized Plan of Care with our **Integration Plus Population Health (Integration+)** platform and facilitate ICT meetings between the internal CCM team members chosen based on the enrollee's needs (e.g., Housing Coordinators, Community Health Workers, BH Liaisons) and the external providers and CBOs. Our Provider Services team guides providers along the integration continuum driven by **our Valued Care Plus (Valued Care+) value-based purchasing (VBP) model that incentivizes coordinated referrals, co-located physical and BH services, and fully integrated facilities.** Through practice transformation, we engage providers in readiness assessments, ongoing education and coaching, and advanced data sharing capabilities. We monitor the success of integrated care for

enrollees and providers and adjust as we identify gaps and improvement opportunities.

Increasing Access to Care: Through our dedicated Medicaid recruitment model in Louisiana, we have invested heavily in specialized BH service providers and innovative partnerships to drive Empowered Care+ with evidence-based programs and supports. **This includes the Volunteers of America (VOA) and their Family-Focused Recovery program for mothers experiencing substance use disorder (SUD), the National Alliance on Mental Illness (NAMI) to offer enrollees direct support through our national partnership and local chapters, and the Bridge Center for Hope, whose Living Room model provides those in crisis with a compassionate, peer-supported, "no-wrong door" approach to immediate help.** Our network includes psychiatric hospitals, mental health rehabilitation agencies, SUD residential treatment facilities, and assertive community treatment (ACT) providers. To help the formerly incarcerated, we partner with VOA, The First 72+, and other local partners to connect them with halfway houses and coordinate rapid housing. Recognizing the mental health crisis for children, we also partner with treatment programs that use Multi-Systemic Therapy, Functional Family Therapy, Homebuilders® Evidence-Based Program, and Applied Behavioral Analysis providers, reflected in **Figure 2.6.15.1-2**.

Figure 2.6.15.1-2: Increasing access to specialized BH and addiction treatment services.

Comprehensive Enrollee Experience: We incorporate our human care company culture into all we do. As a local team living and working in the parishes we serve, this means helping our neighbors knowing they may be experiencing food insecurity, trauma from adverse childhood experiences (ACEs) or the COVID-19 pandemic, and co-existing physical and BH conditions. **Trained in trauma-informed care practices and health equity, our Case Managers who are experts in integrating physical and behavioral health serve as enrollees' single point of contact for navigating their integrated care experience.** Leveraging motivational interviewing, we empower the enrollee by listening to their needs, identifying and establishing personal and health goals, and asking their permission when determining members of their ICT. Case Managers lead the ICT and prioritizes the Plan of Care specific, measurable, assignable actionable, realistic, and time oriented (SMART) goals, which outline the objectives that need to be accomplished and the associated timeline. Our Integration+ platform captures assessment answers, SDOH needs, and informs ongoing development of the Plan of Care.

Coordinated, Co-Located, or Integrated Provider Models: Empowered Care+ makes the process of coordinating integrated care appointments simple **by adjudicating same-day claims for payments for multiple providers and removing logistical barriers from our PCPs and specialized BH providers** to deliver those integrated care services as a team. We begin by training providers on the web-based Compass platform to make closed-loop referrals to local BH providers and CBOs. We help providers scale along the integration continuum from making referrals to delivering co-located or fully integrated services through Value Care+ incentive models, funding from our Practice Transformation Fund, and curated practice transformation education and one-on-one coaching.

Telehealth Expansion: In 2020, Humana's integrated Medicaid programs experienced more than 210,000 telehealth visits for physical and BH conditions. **We connect enrollees to existing telehealth**

[redacted]. These capabilities enable same-day appointments and facilitate bidirectional access between PCPs and BH providers requiring assistance. PCPs and OB/GYNs have access to psychiatric consultations, and we assist practices with purchasing [redacted]

Creating a Culture of Wellness: **Table 2.6.15.1** describes many of the SDOH needs our Empowered Care+ model supports to create a culture of wellness as a primary component of integrated care.

Table 2.6.15.1: Creating a Culture of Wellness

SDOH Support for Healthy Louisiana	
Gambling Addiction Support	Identification, coordination, and referral to Louisiana's Problem Gambling Helpline and the Center for Recovery (CORE) in Shreveport for enrollees in need of addiction support
Reducing Stigma of SUD	Accessing NAMI education resources and connecting enrollees with trusted partners such as Oceans Healthcare and Groups Recover Together for access to treatment and counseling
Suicide Prevention	Addressing stigma and coordinating support with the Louisiana Youth Suicide Prevention S.T.A.R. Plan, the Fisher Project, and the national Zero Suicide model in use by the HSD/HSAs
Food Insecurity	Support to provide enrollees with access to healthy, nutritious foods through value-added benefits (VABs) and local programs such as the Second Harvest Food Bank mobile pantry
Housing First Strategy	Humana's national homelessness model includes a medical respite care VAB, free civil legal aid to prevent eviction through local partners, and long-term support through partnering with Odyssey House, Start Corp., and Louisiana Balance of State Continuum of Care.
Key Team Members	Office of Behavioral Health-certified Peer Support Specialists, CHWs, Housing Coordinators, and others offer support and connect enrollees to local CBO services to address their SDOH

Experience with Care Models That Support Enrollees' Whole-Person Needs

> In Louisiana, we are partnering with Ochsner Health to develop three new integrated primary care clinics focusing on mild to moderate BH conditions and Odyssey House to treat the integrated needs of individuals with moderate to severe BH diagnoses through a VBP model.

Serving Louisiana residents since 1985, Humana is deeply familiar with and passionate about supporting the most vulnerable in local parishes. We bring experience with care management and delivery models to support the whole-person needs of our enrollees through our Empowered Care+ model, which will continue to evolve with input from LDH and our other Medicaid health plans. Humana currently manages Medicaid benefits for nearly 900,000 Medicaid enrollees in Florida, Kentucky, Wisconsin, South Carolina, and Illinois, and **serves more than 450,000 enrollees in our Medicare, Commercial, and TRICARE health plans across all 64 Louisiana parishes.** [redacted]

Strategy for Training and Educating Employees and BH Providers to Deliver and Manage Services

Our comprehensive strategy for training and educating employees and BH providers to deliver and manage services complies with all federal mental health parity requirements:

> Humana promotes local Project ECHO™ training programs such as Tulane's Medication Assisted Treatment training and is exploring new education opportunities with local partners such as the LSU Centers for Evidence to Practice.

Training and Education for Employees: We train all enrollee-facing associates on integrated care during orientation and ongoing training and education, including health inequity, cultural competency, and reducing mental health stigma. Training curriculum includes motivational interviewing techniques, local Louisiana issues such as PTSD associated with natural disasters and COVID-19, Mental Health First Aid (MHFA) Training developed by the National Council for BH, and trauma-informed care training developed by the Bounce Coalition. Our CCM team, including Case Managers, learn best practices for integrated care, including screenings, health assessments, coordinating the referral process, and using the Integration+ platform to maintain enrollees' Plan of Care. Case Manager training includes LDH's required curriculum, such as processes for working with the Coordinated System of Care (CSoC), the Office of Juvenile Justice, the Department of Child and Family Services, and the Office of Aging and Adult Services. Housing Coordinators learn about Permanent Supportive Housing (PSU) and how to help enrollees with applications, and Transition Coordinators and PASRR Level II Evaluators are trained on the United States Department of Justice (DOJ) Target Population and Diversion Plan. We train our Provider Services team on Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration's (SAMHSA-HRSA's) levels of integration, practice readiness, and providing one-on-one coaching support.

Training and Education for BH Providers: We will use the Integrated Practice Assessment Tool (IPAT) results and ongoing provider feedback to continuously add relevant integration training and education topics to our curriculum. Provider Relations staff work with BH providers to develop a curated education program that fits their needs and is available at their own pace in-person, virtual, or recorded web-based, with many courses eligible for continuing education credit. Training addresses administrative and clinical aspects of integrated care, such as billing and claims, making referrals to a PCP, and meeting quality measures. **MHFA training provided by NAMI includes TIC education to address PTSD conditions**, and BH providers can select from more than 300 eLearning Library courses and more than 100 topics on integrated care, including Integrating Primary Care and BH; Integrated Treatment Planning; Serious Mental Illness (SMI) and Respiratory Disease; and Addressing Obesity in Individuals with Mental Illness.

2.6.15.2.1 Enhancing Detection and Treatment of Behavioral Health Disorders

We assist providers with enhancing detection and treatment of BH disorders (including risk of opioid dependence) in primary care settings to screen, refer, and coordinate treatment. Our Provider Toolkit includes screening tools and health assessments to identify BH disorders using the GAD-7, AUDIT, PHQ-9, Mini-Mental State Exam (MMSE), VAMC SLUMS, and ADHD Vanderbilt Screening tools. Recognizing a drastic increase in overdose deaths in parishes such as Lafayette and East Baton Rouge, we assist PCPs in detecting risk of opioid dependence as early as possible to prevent addiction, overdose, and death. **We train providers** on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model, the **Care; Relax; Alone; Forget; Friends; Trouble (CRAFFT)** and Screening to Brief Intervention (S2BI) screening tools to detect opioid dependence in adolescents. Training includes a curated education program and one-on-one, in-person, and virtual provider guidance on incorporating screenings into their routine. NAMI training helps providers detect trauma and adverse childhood events (ACEs) using the ACE questionnaire, and we provide screening tools to detect eating disorders, ADHD, and suicidal ideation.

Case Management Support for Enhancing Detection of BH Disorders
Our Integration+ platform uses predictive modeling to proactively assess enrollee data, including claims, diagnoses, and results of Health Needs Assessments that detect physical, BH, and SDOH needs. Upon detection or change in condition, Case Managers engage enrollees and work with PCPs and BH providers to begin treatment. To ensure screenings occur, we monitor use through office audits, identify improvement opportunities and trends, and engage

providers in education. We improved data collection capabilities for the Depression Screening and Follow-Up for Adolescents and Adults HEDIS® measure and will work with LDH to establish best practices for monitoring. For hard-to-reach enrollees, such as individuals experiencing homelessness or formerly incarcerated suffering from addiction, CHWs work with homeless shelters, Louisiana's Sheriff Association, and local parish jail systems. We identify and connect enrollees with their PCPs and a BH providers to screen for BH disorders and enrollment in Care Management.

Enhancing Treatment of BH Disorders

We help PCPs enhance treatment of BH disorders by providing them with the support, tools, and education they need to facilitate integrated services as the next step once a BH disorder is detected. Our LDH-required Clinical Practice Guidelines (CPGs) guide treatment planning providing next steps for enrollees with conditions such as anxiety, depression, ADHD, schizophrenia, and bipolar disorder. **We distribute BH Referral Sheets to our PCPs, OB/GYNs, and their office staff that contain a list of local BH providers accepting new patients that can be referred to telephonically or using the Compass platform.** For PCPs in rural locations, we assist with telehealth adoption or provide them with a connection to a consultation with a psychiatrist or our Doctors on Demand partnership for integrated care support. Our Case Managers are cross trained in physical and BH and work directly with the PCP or OB/GYN to coordinate the integrated care process with the BH provider and other members of the ICT.

Our CCM team associates, such as CHWs (described in **Figure 2.6.15.2-1**), Housing Coordinators, and Peer Support Specialists, are selected based on enrollees' needs and to support the treatment process through guidance and addressing SDOHs with local CBOs. **Our national partnership with NAMI provides access to the NAMI National HelpLine for free peer support, a resource library for targeted education, and support groups at local chapters.** We support PCPs and BH providers using powerful data analytics capabilities of the Integration+ platform using enrollee data and insights, and updated Plans of Care, available directly on our provider portal. All enrollee-facing associates provide education and access on our Nurse Advice and BH Crisis Lines and our digital self-management tools.

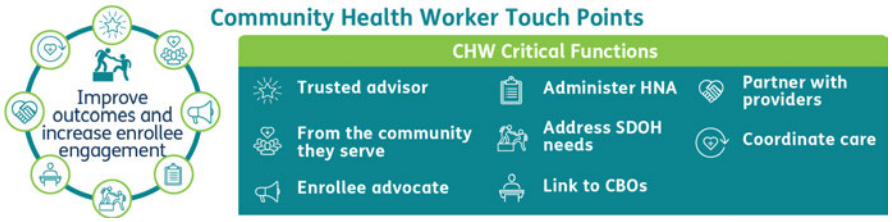


Figure 2.6.15.2-1 CHW Supporting

Enhancing Treatment of Opioid Dependence

Our Opioid Use Disorder (OUD) Program and Opioid Task Force follow the National Council of Wellbeing's recovery-oriented system of care, focusing on enrollee early intervention, treatment, and recovery. We partner with local organizations like Groups Recover Together, Odyssey House, and Oceans Healthcare for treatment and weekly counseling to put enrollees on sustainable paths to recovery. We educate and incentivize PCPs to use the SBIRT tool and refer to local medication assisted treatment (MAT) providers. Using network capacity building and care coordination efforts, our Florida health plan experienced a 40% increase in MAT utilization from 2019-2020. Across all lines of business, Humana experienced a 43% decrease in concurrent opioid and benzodiazepine utilization since 2016. We are partnering with VOA to offer Family-Focused Recovery programs to help mothers with SUD recover and address underlying concerns that inhibit recovery. We help facilitate PCP and patient-centered medical home (PCMH) training for MAT certification; offer Doctors on Demand to fill ICT gaps; educate enrollees on non-pharmacologic treatments VABs, and help providers improve prescribing practices with our BH Drug Utilization Review program.

2.6.15.2.2 Coordination of Care for Enrollees with both Medical and BH Disorders

According to LSU Research Works on Mental Health, almost 20% of Louisiana's citizens were already living with mental illness before the start of the COVID-19 pandemic. As the **State Health Assessment Dashboard reports high rates of obesity, diabetes, and heart disease in many local parishes,** we know that many children and adults experience medical conditions that co-exist with BH disorders. To help enrollees address both, we will coordinate integrated care services and help them navigate care settings and make decisions that impact their recovery journey. Our coordination of care process begins by

identifying enrollees with both medical and BH disorders through PCP or BH provider detection, outreach for hard-to-reach enrollees, the Integration+ predictive algorithm, Health Needs Assessment (HNA) results, or change of status from a referral or care transition. **Depending on the primary condition, either the Physical or BH Case Manager serves as the single point of contact to guide enrollees through recovery and management of their condition.** Case Managers perform in-person enrollee outreach to administer our Comprehensive Care Assessment to identify all physical, BH, and SDOH needs, and then stratify enrollees into LDH-defined risk tiers: 1) low, 2) medium, and 3) high. At in-person visits, Case Managers listen to enrollees' personal and health goals and include family, based on enrollees' preference. Case Managers work with enrollees and identified ICT members to develop person-centered, comprehensive Plans of Care with SMART goals that define ICT roles for both medical and BH conditions, treatment plans, and associated timelines. Case Managers, CHWs, Housing Coordinators, and Peer Support Specialists ensure coordination and deployment of clinical or social support services and monitor outcomes as enrollees progress along their recovery journey. Case Managers monitor enrollees in-person and telephonically to confirm and reinforce SMART goals progress and outcomes.

We recently attended the Child Mental Health Summit hosted by Children's Hospital that discussed the mental health crisis in Louisiana for children experiencing increased rates of depression, anxiety, and suicidal ideation. We have BH-trained Case Managers dedicated to serving this population and will coordinate with the CSoC program and the enrollee's ICT to align treatment plans, address care gaps for unaddressed physical health conditions, and prepare for when the enrollee is ready to transition out of the CSoC program to receive full Humana benefits for both physical and BH conditions.

Promotion of Care Transition for Enrollees with Co-Existing Medical-Behavioral Health Disorders

Our Empowered Care+ model facilitates care transitions between inpatient services, residential services, and outpatient care through our Transitional Care Management program. **On-site Nurse Liaisons (currently active for Louisiana Medicare) provide in-person discharge coordination for high-volume facilities granting permission.** We support transitions between institutional and community care settings, including members of the DOJ Target Population, Psychiatric Residential Treatment Facilities, Therapeutic Group Homes, and Integrated Care Facilities for Individuals with Intellectual Disabilities (ICF/IDs). Case Managers coordinate with the ICT to establish outpatient and SDOH services 30 days prior to discharge. Utilization Management (UM) Coordinators work with BH providers to determine the appropriate level of care; share the Transitional Plan of Care with PCPs and outpatient BH providers; and schedule bridge visits when necessary. Housing Coordinators connect enrollees experiencing homelessness with housing partners and help them apply to the PSH program. We follow up with the enrollee and providers at seven and 30-day appointments to facilitate and support transitions.

Supporting the DOJ Target Population
Our PASRR Level II Evaluators and UM Coordinators will work with the My Choice Transition Coordinator to develop a person-centered Transitional POC and discharge plan to support enrollees ready for transition back to their community. To assist, Housing Coordinators and CHWs will identify and connect the enrollee to services to support their SDOH needs. Prior to discharge, we communicate the enrollee's needs and Plan of Care to the PCP and ensure that appointments to support their co-existing health conditions, including SMI, are established with their ICT team. We provide ongoing support and communication to monitor the Plan of Care, identify and address care gaps, assess health and safety in the community, and confirm the enrollee's preferences continue to be sufficiently reflected.

2.6.15.2.3 Incenting and Tracking Providers Progress in Delivering Integrated Care

Humana's Valued Care+ VBP model offers incentives and tracks progress in delivering integrated care through greater care coordination, transparency, and communication between primary care and BH providers. Our Provider Services team uses the results from the IPAT and our Medicaid VBP Readiness Assessment to evaluate a provider's level of integration between physical health, BH, and SDOH. Once we understand their capabilities and desired level of integration, we help them build a pathway to

achieve their goals through practice transformation incentives, education, and support. [redacted]

Humana currently has 64 provider groups engaged in Louisiana Medicare Advantage VBP contracts that support more than 2,400 providers and 126,000 enrollees to increase preventive care and integrated health outcomes and decrease hospital admission rates and overall care costs.

[redacted]

Closed-Loop Referrals for Clinical and SDOH Needs

To drive integration, providers can easily make closed-loop referrals to CBOs to address SDOH and clinical providers (e.g., PCP to BH) for integrated care. This closed-loop referral system advances the capabilities of our partners by connecting network providers with clinical and social service providers, enabling tracking and closing of referrals, and allowing us to incent service providers to follow-up and close referrals to social services.

[redacted]

2.6.15.2.4 Assistance for Providers to Improve Care Integration

The Provider Services team facilitates tools, guidance, and financial incentives to improve BH and physical health integration based on a provider's desired level of integration. In addition to practice transformation coaching and our curated education program, we offer the following assistance:

Table 2.6.15.2: Tools, Guidance, and Financial Incentives to Develop Skills and Infrastructure

Financial Incentives	Humana's Practice Transformation Fund supports eligible PCPs and BH providers seeking to build integration at their practice with the funding to invest in components of integrated care such as telehealth equipment, translation technology, qualified interpreters, or bilingual staff, EHR, or any resources related to the components of integrated care listed below. Our VBP models incentivize coordination and follow-up between providers, and we use flexible contracting strategies to encourage integrated practices to join Humana's network, such as enhanced fee schedule rates.

Schedule Joint Appointments	We educate providers on scheduling joint appointments to facilitate same-day enrollee access based on their level of integration, including co-located appointments or virtual joint appointments leveraging telephonic or video/telehealth platforms, including Doctors on Demand.
Develop Shared Care Plans	Humana's Care Profile application in our provider portal enables providers to view their enrollees and their Plans of Care. Education and training include working with the Case Manager and ICT to develop the shared Plan of Care (with enrollee consent) and meeting the enrollee's SMART goals.
Conduct Effective Brief Assessment	We provide training on using the evidence-based screening tools and assessments in our Provider Toolkit, which includes incorporating effective brief assessments such as the SBIRT, CRAFFT, and S2BI screening tools into their patient routine to identify the need for integrated care.
Integrate Records	We train providers on our provider portal, which stores an enrollees integrated record that includes referrals and the Plan of Care maintained by the Case Manager and ICT. The portal is available 24/7 and enables practices to access key information, including referral reports, authorization forms and approvals, enrollee admissions, discharges, transfers, and claim status.
Make and Follow Up on Referrals	We educate providers on making referrals and following up in collaboration with the PCP or BH provider. The BH Quality Rewards Program incentivizes referrals and follow-up appointments, and PCPs in our Medical Home pilot program receive incentives for performing best practice treatments such as meeting Follow-Up Care HEDIS measures for children with ADHD and adults with depression. Our Care Decision Insights platform provides PCPs with information about specialists in their region to help them make more informed referrals, and we train providers to use the SDOH and clinical referral platform to connect enrollees to providers and local CBOs.
Co-Locate Services	We educate and incentivize providers ready to establish co-located services to achieve Level 3 and Level 4 integration (co-location) on the SAMHSA-HRSA continuum. This includes learning to collaborate with on-site providers on shared patient, screenings, and evidence-based practices; removing system barriers such as patient records; developing an internal referral process; engaging in warm hand-offs; and participating in mutual problem-solving and treatment planning.
Track Outcomes	PPIAs provide targeted, one-on-one assistance to review HEDIS quality measures and help close care gaps associated with VBP arrangements. They assist providers with using our data analytics to develop improvements that drive better quality metrics, close care gaps, and receive incentives for successfully coordinating and engaging in integrated care. We work with providers to scale their integration model at their own pace and offer ongoing practice transformation coaching.

2.6.15.2.5 Identifying People Using ED Services to Assist in Scheduling Follow-up Care

Humana attended the 2021 BH Day sponsored by the Mental Health Association of Baton Rouge, which discussed the issue of using ED as a primary means of seeking help. Our Diversion Program includes the following best practices to identify and coordinate enrollee follow-up care with the PCP or BH specialist:

Identify Enrollees: We receive daily enrollee reports containing primary and secondary BH diagnoses organized by individuals with non-urgent conditions and multiple ED visits within the past 12 months (by region). We also monitor for enrollees experiencing an overdose or crisis, which may be our first opportunity to contact and engage them in Care Management support. We receive notifications of BH-related visits through participation with the Louisiana Health Information Exchange (LHIE). Through our national partnership with Collective Medical, we have access to their innovative ED-reporting platform that facilitates daily, configurable reports to identify enrollees and begin engaging them in care.

Initiate Outreach Campaign: Once identified, we engage enrollees in Humana's *Where to Get Care* outreach campaign to provide education on the importance of establishing and maintaining a relationship with the PCP and BH specialist in their community. Education materials describe how and where to receive care (such as urgent care) and text messages linking to learning materials and nearby healthcare locations. For hard-to-reach/unable to contact enrollees, we contact pharmacies and local Emergency Medical Service (EMS) providers to find their most recent contact information.

Schedule Appointments: Once engaged, Humana Case Managers and CHWs work with the enrollee to schedule appointments with a PCP and BH provider to begin their integrated treatment plan and

establish a new routine of seeking care with their assigned providers in the community. The goal is to maintain their treatment in less costly care settings that surround them with whole-person health services and addiction support, if applicable. **In Louisiana, we are partnering with Ochsner Health's Anywhere Care virtual platform to provide urgent care access for immediate medical attention**.

Coordinate Ongoing Support: Case Managers and CHWs proactively track enrollees and their follow-up appointments through in-person meetings to ensure they have the support to address chronic, co-existing health conditions and SDOH needs. Peer Support Specialists provide one-on-one guidance, helping the enrollee navigate the integrated healthcare continuum and empowering them to participate in their recovery by attending their appointments and working toward their SMART goals. We either develop a crisis plan or integrate an existing Plan of Care from their BH provider that enables them to identify warning signs, access local support systems, and use techniques that reduce symptoms when at risk for a crisis to prevent the use of the ED or hospitalization.

Partner with Crisis Continuum: We coordinate with crisis response providers in local parishes to help enrollees with support from our BH Crisis Line, crisis plans, and ongoing Care Management services to avoid preventable ED visits and maintain their care with trusted providers in the community. Recognizing LDH's plan to build a better, more connected continuum of crisis support services in the State, our network maximizes the availability of community-based BH care to reduce ED utilization. We will also implement a paramedicine pilot program that leverages telehealth technology to develop a network of neighborhood responders connecting local EMS and fire departments with providers capable of supporting urgent care needs to prevent unnecessary ED visits.

2.6.15.2.6 Ensuring Continuity and Coordination of Care for Enrollees

Our implementation plan includes processes and procedures tailored to our Empowered Care+ model that adhere to **Model Contract Section 2.8** to successfully facilitate continuity and coordination of care for all enrollees, including those transitioning from other MCOs or fee-for-service. We support individuals screening positive in HNAs, other assessments, or PCP/BH provider tools for and requiring specialized medical and BH services or inpatient and outpatient services. We understand their immediate need to continue treatment consistent with their previous access while transitioning to Humana and will engage through the following processes:

- **Continuity and Coordination of Care Process:** We identify enrollees; coordinate with the MCO and current providers; confirm ongoing preventive and primary care services; establish referrals to BH specialists; authorize medications; and identify special considerations such as high-risk pregnancies, conditions that require ongoing monitoring, and scheduled surgeries and appointments.
- **Coordination with MCOs/LDH:** Our BH Liaison and designated associates coordinate with MCOs and LDH departments to facilitate continuity and coordination of care for all enrollee populations. Departments include OBH, DCFS, OAAS, OJJ, Office for Citizens with Developmental Disabilities, Department of Education (DOE), and Department of Public Safety and Corrections (DPS&C).

Referral and Follow-Up with Enrollees Requiring BH Services

The assigned Case Manager ensures successful referrals, continuance of medication, and follow-up appointments for enrollees requiring BH services. Our policies and procedures will include mechanisms for collaborating with the appropriate department for children returning into the community from out-of-home placement, nursing facilities and ICF/IDs, inpatient and residential facilities, hospitals, and the

DPS&C and local criminal justice systems. We train our providers to screen for BH conditions and refer enrollees to the appropriate BH service. The BH Quality Rewards Program incentivizes providers to complete 7- and 30-day follow-up appointments, shifting the focus to long-term outcomes for recovery.

> Humana awarded the Rapides Foundation with a grant to support physical and BH integration within the local school systems. The goal of the program is to increase enrollee access and improve BH care quality and outcomes for children with physical, BH, or co-existing conditions for those receiving treatment at FHQCs and School-Based Health Clinics within the nine rural parishes supported by the Rapides Foundation in Central Louisiana.

Continuity of Care for School-Aged Children: As the COVID-19 pandemic continues, we recognize the enormous impact and strain put on local school systems and children who have missed a year of learning and development. Recognizing the trauma occurring in our communities (including a rising suicide rate), we will have proper resources in place to help children with special healthcare needs, many of whom require services from multiple providers, facilities, and agencies and require complex coordination of benefits and services. **Our BH Liaison will coordinate with the CSoC Coordinator to facilitate their care to ensure we address their medical needs and coordinate with school-based health centers** located at local FQHCs. [redacted]

Continuity of Care for the Justice-Involved: Formerly incarcerated enrollees in Louisiana experience co-existing conditions at an exceptionally high rate due to opioid use and a cycle of recidivism perpetuated by a lack of clinical and social reentry supports. Our Empowered Care+ model begins enrollee support 30-45 days prior to release through our Reentry Program for those diagnosed with SMI. To ensure continuity of care, the Case Manager collaborates with the facility's medical team and attends planning meetings with the parole officer to assess the enrollee, develop the Plan of Care, and schedule their appointments before release to address any preventive, chronic, and complex health issues with providers in the community. This includes organizations such as the Formerly Incarcerated Transitions Clinic focusing on primary care services and the local HSD/HSA to manage their BH conditions and provide counseling and OUD/SUD treatment. **We connect the enrollee to local CBOs, such as** [redacted] Based on their needs, we assign a Peer Support Specialist, CHW, or Housing Coordinator to assist with the transition. We have also reached out to Louisiana's Sheriff Association, DPS&C, and parish coroners to begin additional discussions on enhancing reentry services.

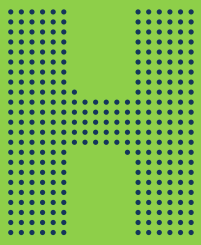
Kingsley House Adult Day Care participants are given the opportunity to socialize, receive nursing services, care management, and personalized nutritious meals and snacks. Participants engage in fun and stimulating daily activities. Humana Healthy Horizons in Louisiana is partnering with Kingsley House to address a myriad of enrollees' needs.

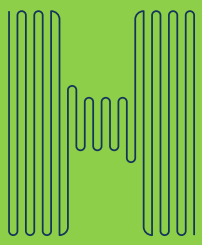
Sections 1.44 & 4.4

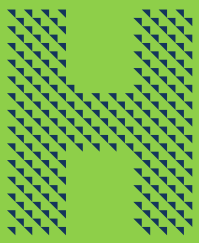
Veteran and Hudson Initiative Programs Participation

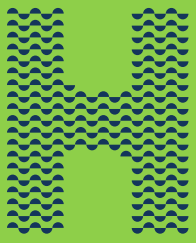
Humana

Healthy Horizons™
in Louisiana









1.44 and 4.4 Veteran and Hudson Initiative Programs Participation

4.4 Veteran and Hudson Initiative Response

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