HUMANA INC
Form 10-K
February 18, 2015
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

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

For the fiscal year ended December 31, 2014
OR

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

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

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

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

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

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

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2014 was $19,712,008,342 calculated using the average price on June 30, 2014 of $128.11.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2015 was 149,607,897.

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 16, 2015.

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Forward-Looking Statements

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

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as “we,” “us,” “our,” the “Company” or “Humana,” is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. As of December 31, 2014, we had approximately 13.8 million members in our medical benefit plans, as well as approximately 7.7 million members in our specialty products. During 2014, 73% 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 542,400 members as of December 31, 2014.

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 2014 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2014 Form 10-K for a description of a number of factors that may adversely affect our results or business.

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. Implementation dates of the Health Care Reform Law began in September 2010 and will continue through 2018, and many aspects of the Health Care Reform Law are already effective and have been implemented by us. 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, an annual insurance industry premium-based assessment, and a three-year commercial reinsurance fee. The

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Health Care Reform Law is discussed more fully in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Care Reform."

Business Segments

On January 1, 2014, we reclassified certain of our businesses from our Healthcare Services segment to our Employer Group segment to correspond with internal management reporting changes. Our reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. See Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for segment financial information.

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

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, generally require a referral from the member's primary care provider before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. However PPOs generally require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy, provider, home based, and integrated wellness services. 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, 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.

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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, 2014:

	Retail Segment Premiums and Services Revenue (dollars in millions)	Percent of Consolidated Premiums and Services Revenue	
Premiums:			
Individual Medicare Advantage	$25,941	53.9	%
Medicare stand-alone PDP	3,396	7.1	%
Total Retail Medicare	29,337	61.0	%
Individual commercial	3,265	6.8	%
State-based Medicaid	1,096	2.3	%
Individual specialty	256	0.4	%
Total premiums	33,954	70.5	%
Services	39	0.1	%
Total premiums and services revenue	$33,993	70.6	%

Individual Medicare

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

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

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, and Private Fee-For-Service, or PFFS, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits

in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data analysis techniques to help identify member needs, complex case management, tools to guide

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members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

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

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

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

At December 31, 2014, we provided health insurance coverage under CMS contracts to approximately 2,446,200 individual Medicare Advantage members, including approximately 542,400 members in Florida. These Florida contracts accounted for premiums revenue of approximately $7.2 billion, which represented approximately 27.8% of our individual Medicare Advantage premiums revenue, or 15.0% of our consolidated premiums and services revenue for the year ended December 31, 2014.

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 2015, and all of our product offerings filed with CMS for 2015 have been approved.

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Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP plan co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Medicare Part D Provisions." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2015, and all of our product offerings filed with CMS for 2015 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.

Medicare and Medicaid Dual Eligible and Long-Term Care Support Services

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. There were approximately 9.6 million dual eligible individuals in the United States in 2014, trending upward due to Medicaid eligibility expansions and individuals aging into the Medicare program. These dual eligibles may enroll in a privately-offered Medicare Advantage product, but may also receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. The dual eligible population is a strategic area of focus for us and we are leveraging the capabilities of our integrated care delivery model, including care management programs particularly as they relate to chronic conditions, to expand our services to this population. As of December 31, 2014, we served approximately 404,000 dual eligible members in our Medicare Advantage plans and approximately 992,000 dual eligible members in our stand-alone prescription drug plans.

Since the enactment of the Health Care Reform Law, states are pursuing stand-alone dual eligible CMS demonstration programs in which Medicare, Medicaid, and Long-Term Care Support Services (LTSS) benefits are more tightly integrated. Eligibility for participation in these stand-alone dual eligible demonstration programs may require state-based contractual relationships in existing Medicaid programs. We were successful in our bids for state-based contracts in Florida and Virginia in 2013 and in Ohio, Illinois, and Kentucky in 2012. Ohio, Illinois, and Virginia are contracts for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the state-based Medicaid program. We began serving members in Illinois in the first quarter of 2014 and in Virginia in the second quarter of 2014. We partner with organizations, including CareSource Management Group Company, to serve individuals in certain states. We began serving members in Kentucky and certain LTSS regions in Florida at various effective dates ranging from the second half of 2013 through the first quarter of 2014.

LTSS eligible beneficiaries heavily overlap with the dual eligible population. On September 6, 2013, we acquired American Eldercare Inc., or American Eldercare, the largest provider of nursing home diversion services in the state of Florida, serving frail and elderly individuals in home and community-based settings. American Eldercare complements our core capabilities and strength in serving seniors and disabled individuals with a unique focus on individualized and integrated care, and has contracts to provide Medicaid long-term support services across the entire state of Florida. The enrollment effective dates for the various regions ranged from August 2013 to March 2014.

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Individual Commercial Coverage

Our individual health plans are marketed under the HumanaOne® brand. We offer products both on and off of the public exchange, including exchange offerings in certain metropolitan areas in 15 states. We offer products on exchanges where we can achieve an affordable cost of care, including HMO offerings and select networks in most markets. Our off-exchange products offered in 22 states are primarily PPO and POS offerings, including plans issued prior to 2014 that were previously underwritten. Policies issued prior to the enactment of the Health Care Reform Law on March 23, 2010 are grandfathered policies. Grandfathered policies are exempt from most of the requirements of the Health Care Reform Law, including mandated benefits. However, our grandfathered plans include provisions that guarantee renewal of coverage for as long as the individual chooses. Policies issued between March 23, 2010 and December 31, 2013 are required to conform to the Health Care Reform Law, including mandated benefits, upon renewal in 2014, 2015 or 2016, depending on the state.

Prior to 2014, our HumanaOne® plans primarily were offered as PPO plans in 27 states where we could generally underwrite risk and utilize our existing networks and distribution channels. As indicated above, this individual product included provisions mandated by law to guarantee renewal of coverage for as long as the individual chooses. Rewards-based wellness programs are included with many individual products. We also offer optional benefits such as dental, vision, life, and a portfolio of financial protection products.

Employer Group Segment Products

This segment is comprised of products sold to employer groups including medical and supplemental benefit plans as well as health and wellness products as described in the discussion that follows. The following table presents our premiums and services revenue for the Employer Group segment by product for the year ended December 31, 2014:

	Employer Group Segment Premiums and Services Revenue (dollars in millions)	Percent of Consolidated Premiums and Services Revenue	
External Revenue:			
Premiums:			
Group Medicare Advantage	$5,490	11.4	%
Group Medicare stand-alone PDP	8	—	%
Total group Medicare	5,498	11.4	%
Fully-insured commercial group	5,339	11.1	%
Group specialty	1,098	2.3	%
Total premiums	11,935	24.8	%
Services	362	0.8	%
Total premiums and services revenue	$12,297	25.6	%
Intersegment services revenue:			
Wellness	$78	n/a	
Total intersegment services revenue	$78		

n/a – not applicable

Employer 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

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Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government's health insurance program for Federal employees, retirees, former employees, family members, and spouses. As with our individual commercial products, the employer group offerings include HumanaVitality®, our wellness and loyalty reward program.

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

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

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.

Wellness

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

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

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

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, home based services, integrated behavioral health 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, 2014:

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	Healthcare Services Segment Premiums and Services Revenue (dollars in millions)	Percent of Consolidated Premiums and Services Revenue	
Intersegment revenue:			
Pharmacy solutions	$16,905	n/a	
Provider services	1,110	n/a	
Home based services	585	n/a	
Integrated behavioral health services	133	n/a	
Total intersegment revenue	$18,733		
External services revenue:			
Provider services	$1,076	2.3	%
Home based services	107	0.2	%
Pharmacy solutions	99	0.2	%
Integrated behavioral health services	—	—	%
Total external services revenue	$1,282	2.7	%

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 RightSourceRx®, as well as research services.

Provider services

Our subsidiary, Concentra Inc.®, acquired in 2010, delivers occupational medicine, urgent care, physical therapy, and wellness services to employees and the general public through its operation of medical centers and worksite medical facilities.

Our CAC Medical Centers, or CAC, in South Florida operate full-service, multi-specialty medical centers staffed by primary care providers and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry.

Our subsidiary, Metropolitan Health Networks, Inc., or Metropolitan, and our noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, both acquired in 2012, are Medical Services Organizations, or MSOs, that coordinate medical care for Medicare Advantage beneficiaries and Medicaid recipients, primarily in Florida and Texas. These MSOs represent key components of our integrated care delivery model which we believe is scalable to new markets.

Home based services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Home based services include the operations of Humana At Home, Inc., or Humana At Home® (formerly known as SeniorBridge Family Companies, Inc.), acquired in 2012. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies, such as Florida, with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home® is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility.

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Integrated behavioral health services

Corphealth, Inc. (d/b/a LifeSynch®), a Humana subsidiary, offers care management, behavioral health services and wellness programs.

Other Businesses

Products and services offered by our Other Businesses are described in the discussion that follows. The following table presents our premiums and services revenue for our Other Businesses for the year ended December 31, 2014:

	Other Businesses Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue	
	(dollars in millions)		
Premiums:			
Military services	$19	—	%
Closed-block long-term care insurance policies	51	0.1	%
Total premiums	70	0.1	%
Services	481	1.0	%
Total premiums and services revenue	$551	1.1	%

Military Services

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

Closed Block of Long-Term Care Insurance Policies

We have a non-strategic closed block of approximately 32,700 long-term care insurance policies associated with our acquisition of KMG America Corporation in 2007. Long-term care insurance policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block and we are evaluating strategic alternatives for this business.

Informatics

Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We believe that technology represents a significant opportunity in health care that positively impacts our members. We have enhanced our health information technology capabilities enabling us to create a more complete view of an individual’s health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews millions of clinical data points each day to provide members, providers, and payers real-time clinical insights and gaps-in-care data to improve health outcomes, as well as technology that allows disparate electronic health record systems and Humana to share data that gives providers a comprehensive view of the patient and enables the exchange of essential health information in real-time. As we have integrated these and related assets into our operations over the past few years, we have enhanced our ability to leverage predictive modeling capabilities that enable us to anticipate, rather than react to, our members’ health needs. To that end, we have accelerated our process for identifying and reaching out to members in need of clinical

intervention. At December 31, 2014, we had approximately 420,700 members with complex chronic conditions in the Humana Chronic Care Program,

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a 50.1% increase compared with approximately 280,200 members at December 31, 2013, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Membership

The following table summarizes our total medical membership at December 31, 2014, by market and product:

	Retail Segment (in thousands)				Employer Group Segment						
	Individual Medicare Advantage	Individual Medicare stand-alone PDP	Individual Commercial	State-based contracts	Fully-insured commercial Group	Group Medicare Advantage and stand-alone PDP	ASO	Other Businesses	Total	Percent of Total	
Florida	542.4	300.6	252.7	293.7	189.7	22.6	28.3	—	1,630.0	11.8	%
Texas	184.0	258.5	181.6	—	238.6	63.2	118.2	—	1,044.1	7.5	%
Kentucky	74.5	185.6	27.3	—	101.8	81.0	472.1	—	942.3	6.8	%
Georgia	92.8	90.3	286.4	—	140.8	2.4	15.8	—	628.5	4.5	%
Ohio	81.3	121.1	21.9	—	48.6	151.0	139.0	—	562.9	4.1	%
Illinois	83.9	126.1	28.8	4.8	108.1	11.6	90.3	—	453.6	3.3	%
California	38.4	378.9	9.6	—	0.1	0.1	—	—	427.1	3.1	%
Wisconsin	51.5	80.2	11.7	—	89.4	14.2	113.3	—	360.3	2.6	%
Missouri/Kansas	82.2	175.6	14.3	—	53.3	5.0	6.9	—	337.3	2.4	%
Tennessee	119.6	87.6	27.8	—	50.5	2.2	39.5	—	327.2	2.4	%
Louisiana	127.9	50.1	22.7	—	63.1	10.5	30.4	—	304.7	2.2	%
North Carolina	79.6	139.9	5.9	—	—	37.4	—	—	262.8	1.9	%
Virginia	131.6	104.8	7.7	—	—	3.9	—	—	248.0	1.8	%
Indiana	71.9	99.6	14.3	—	22.0	3.9	19.5	—	231.2	1.7	%
Michigan	49.1	113.3	34.1	—	8.8	13.8	3.7	—	222.8	1.6	%
Colorado	31.2	75.3	35.1	—	24.3	7.3	0.4	—	173.6	1.3	%
Arizona	56.2	65.2	18.6	—	29.4	1.5	1.5	—	172.4	1.2	%
Military services	—	—	—	—	—	—	—	3,090.4	3,090.4	22.3	%
Others	548.1	1,536.8	147.6	—	67.0	62.6	25.4	35.0	2,422.5	17.5	%
Totals	2,446.2	3,989.5	1,148.1	298.5	1,235.5	494.2	1,104.3	3,125.4	13,841.7	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.

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We have available care management programs related to complex chronic conditions such as congestive heart failure and coronary artery disease. We also have programs for prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

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

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

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

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

Capitation

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

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

At December 31, 2014, approximately 883,000 members, or 6.4% of our medical membership, were covered under risk-based contracts, including 709,000 individual Medicare Advantage members, or 29.0% 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 141,200 HMO members, including 113,200 individual Medicare Advantage members, or 16.0% of the 709,000 individual Medicare Advantage members covered under

risk-based contracts at December 31, 2014, 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

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underlying claims experience was approximately $833 million, or 2.2% of total benefits expense, for the year ended December 31, 2014. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

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

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

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

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

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

Sales and Marketing

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

At December 31, 2014, we employed approximately 1,700 sales representatives, as well as approximately 1,200 telemarketing representatives who assisted in the marketing of individual Medicare and individual commercial health insurance and specialty products in our Retail segment, including making appointments for sales representatives with prospective members. We also market our individual Medicare products via a strategic alliance with Wal-Mart Stores, Inc., or Wal-Mart. This alliance includes stationing Humana representatives in certain Wal-Mart stores, SAM’S CLUB locations, and Neighborhood Markets across the country which provides an opportunity to enroll Medicare eligible individuals in person. In addition, we market our individual Medicare and individual commercial health insurance and specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual commercial health insurance and specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that

attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

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

Underwriting

Beginning in 2014, the Health Care Reform Law requires all individual and group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, newly issued individual and group health plans are not subject to underwriting in 2014 and beyond. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history. Prior to 2014, through the use of internally developed underwriting criteria, we determined the risk we were willing to assume and the amount of premium to charge for our commercial products. In most instances, employer and other groups had to meet our underwriting standards in order to qualify to contract with us for coverage.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have larger memberships 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 2014 Form 10-K.

Government Regulation

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

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

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2014 Form 10-K.

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Certain Other Services

Captive Insurance Company

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

Centralized Management Services

We provide centralized management services to each of our health plans and to our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, billing/enrollment, and customer service.

Employees

As of December 31, 2014, we had approximately 57,000 employees and approximately 2,700 additional medical professionals working under management agreements primarily between Concentra and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

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ITEM 1A. RISK FACTORS

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, however involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends.

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. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

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

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

In addition, we also estimate costs associated with long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental insurance policies sold to individuals for which some

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

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

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

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

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

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

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable

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medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

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

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

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. Over the last few years we have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 72% of our total premiums and services revenue for the year ended December 31, 2014 generated from our Medicare products, in particular our contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

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

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

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

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

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition

activities, we have acquired additional information systems. We have reduced the number of systems we operate, have

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

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

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

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

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

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

The costs to eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our members’ private information and result in the risk of financial or medical identity

theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

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

Federal regulations related to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), contain minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. ICD-9, the current system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States, was scheduled to be replaced by ICD-10 code sets on October 1, 2014. However, on April 1, 2014, The Protecting Access to Medicare Act of 2014 was signed into law, delaying implementation of ICD-10 until at least October 1, 2015. For dates of service on or after the date of final implementation, health plans and providers will be required to use ICD-10 codes for such diagnoses and procedures. While we have prepared for the transition to ICD-10, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after the final implementation date, including providers in our network who are employees, we will have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. If we do not adequately implement the new ICD-10 coding set, or if providers in our network do not adequately transition to the new ICD-10 coding set, our results of operations, financial position and cash flows may be materially adversely affected.

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

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

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

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice;
- claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers’ proposed medical treatment plans for patients;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation or non-acceptance or termination of provider contracts or provider contract disputes relating to rate adjustments resulting from the Balance Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as “sequestration”);

- disputes related to ASO business, including actions alleging claim administration errors;
- qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model;
- claims related to the failure to disclose some business practices;
- claims relating to customer audits and contract performance;

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- 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 76% of our total premiums and services revenue for the year ended December 31, 2014. These programs involve various risks, as described further below.

- At December 31, 2014, under our contracts with CMS we provided health insurance coverage to approximately 542,400 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, 2014. 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, 2014, our military services business primarily consisted of the TRICARE South Region contract which covers approximately 3,090,400 beneficiaries. For the year ended December 31, 2014, premiums and services revenue associated with the TRICARE South Region contract accounted for approximately 1% of our total premiums and services revenue. On April 1, 2012, we began delivering services under the current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government’s option. On January 27, 2015, we received notice from the DHA of its intent to exercise its option to extend the TRICARE South Region contract through March 31, 2016. The loss of the TRICARE South Region contract, should it occur, may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the

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performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.

CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process that bases our prospective payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. 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. In addition, we conduct medical record reviews, as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. 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 provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the Medicare FFS benchmark audit is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to the current round of RADV contract level audits being conducted on 2011 premium payments. Selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year. We have been notified that certain of our Medicare Advantage contracts have been selected for audit for contract year 2011.

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 benchmark audit data in Medicare FFS which has

not yet been released. We based our accrual of estimated audit settlements for contract years 2011 (the first year that application of extrapolated audit results is applicable) through 2014 on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However,

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as indicated, we are awaiting additional guidance from CMS regarding the benchmark audit data in Medicare FFS. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' recent comments in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that Medicare Advantage 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 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 receivable of $69 million at December 31, 2014.

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

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

- The Budget Control Act of 2011, enacted on August 2, 2011, increased the United States debt ceiling conditioned on deficit reductions to be achieved over the next ten years. The Budget Control Act of 2011 also established a twelve-member joint committee of Congress known as the Joint Select Committee on Deficit Reduction to propose legislation to reduce the United States federal deficit by $1.5 trillion for fiscal years 2012-2021. The failure of the

Joint Select Committee on Deficit Reduction to achieve a targeted deficit reduction by December 23, 2011 triggered an automatic reduction, including aggregate reductions to Medicare payments to providers of up to 2 percent per fiscal year. These reductions took effect on April 1, 2013, and the Bipartisan Budget Act of 2013, enacted on December 26, 2013, extended the reductions for

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two years. We expect a corresponding substantial reduction in our obligations to providers. Due to the uncertainty around the application of any such reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs applied by the Budget Control Act of 2011.

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

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

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. The provisions of the Health Care Reform Law include, among others, imposing a significant new non-deductible health insurance industry fee and other assessments on health insurers, limiting Medicare Advantage payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products, additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). In addition, the Health Care Reform Law has increased and will continue to increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms will come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. Implementation dates of the provisions of the Health Care Reform Law began in September 2010 and continue through 2018. If we fail to effectively implement our operational and strategic

initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. For additional information, please refer to the section entitled, “Health Care Reform” in “Item 7 - Management’s Discussion and Analysis of Financial Condition and Results of Operations” appearing in this annual report.

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

The Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products. In addition, regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law may have an adverse effect on our pool of participants in the health insurance exchange. All of these factors may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

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

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

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

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

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

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. On January 17, 2013, HHS issued the omnibus final rule on HIPAA privacy, security, breach notification requirements and enforcement requirements under the HITECH Act, and a final regulation for required changes to the HIPAA Privacy Rule for the Genetic Information Nondiscrimination Act, or GINA. The omnibus final rule became effective on March 26, 2013, with a compliance date of September 23, 2013. Among other requirements, the HITECH Act and Omnibus final rule mandates 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.

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

American Recovery and Reinvestment Act of 2009 (ARRA)

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

Corporate Practice of Medicine and Other Laws

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

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

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

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

prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as “Stark II,” amended prior federal physician self-referral legislation known as “Stark I” by expanding the list of designated health services

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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: 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

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strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives. Among the businesses that we are currently evaluating is our closed block of long-term care insurance policies business. While no decision has been made with respect to any course of action, if we were to divest this business it is reasonably likely that we would have to recognize a material loss that will have a material adverse effect on our results of operations. The divestiture of certain other businesses could also result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations. There can be no assurance that we will be able to complete any such divestitures on terms favorable to us.

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

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

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

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

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

Our pharmacy mail order business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, Internet companies and other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally

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

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

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

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

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

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

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

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and require minimum levels of equity as well as limit

investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of

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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.

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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.

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ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2014:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	14	125	—	94	233
Texas	4	56	2	44	106
California	—	28	—	18	46
Georgia	1	21	—	15	37
Kentucky	2	10	11	11	34
Arizona	1	20	—	9	30
Illinois	—	17	—	12	29
Colorado	—	20	—	9	29
Michigan	—	23	—	3	26
Ohio	—	10	—	16	26
Pennsylvania		16		8	24
Tennessee	—	11	—	13	24
New Jersey	—	14	—	9	23
Louisiana	—	11	—	11	22
Virginia	—	14	—	8	22
New York	—	4	—	13	17
North Carolina	—	6	—	10	16
Missouri	—	12	—	3	15
Nevada		10		5	15
Wisconsin	—	8	1	6	15
Connecticut	—	10	—	3	13
Indiana	—	7	—	6	13
South Carolina	—	2	4	7	13
Maryland	—	10	—	2	12
Oklahoma	—	7	—	5	12
Mississippi	—	—	—	10	10
Puerto Rico	—	—	—	9	9
Others	—	47	—	41	88
Total	22	519	18	400	959

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists, urgent care facilities, and worksite medical facilities. Of the medical centers included in the table above, approximately 54 of these facilities are leased or subleased to our 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.

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ITEM 3. LEGAL PROCEEDINGS

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

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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PART II

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

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2014 and 2013:

	High	Low
Year Ended December 31, 2014		
First quarter	$118.78	$95.59
Second quarter	$128.95	$104.74
Third quarter	$135.51	$115.97
Fourth quarter	$149.07	$124.17
Year Ended December 31, 2013		
First quarter	$81.52	$66.01
Second quarter	$85.17	$72.10
Third quarter	$99.60	$82.93
Fourth quarter	$105.25	$91.21

Holders of our Capital Stock

As of January 31, 2015, there were approximately 3,300 holders of record of our common stock and approximately 40,250 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2013 and 2014:

Record Date	Payment Date	Amount per Share	Total Amount (in millions)
2013 payments			
12/31/2012	1/25/2013	$0.26	$42
3/28/2013	4/26/2013	$0.26	$41
6/28/2013	7/26/2013	$0.27	$42
9/30/2013	10/25/2013	$0.27	$42
2014 payments			
12/31/2013	1/31/2014	$0.27	$42
3/31/2014	4/25/2014	$0.27	$42
6/30/2014	7/25/2014	$0.28	$43
9/30/2014	10/31/2014	$0.28	$43

In October 2014, the Board of Directors declared a cash dividend of $0.28 per share that was paid on January 30, 2015 to stockholders of record as of the close of business on December 31, 2014, for an aggregate amount of $42 million. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

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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, 2014. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2009, and that dividends were reinvested when paid.

	12/31/2009	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014
HUM	$100	$125	$201	$160	$244	$342
S&P 500	$100	$115	$117	$136	$180	$205
Peer Group	$100	$112	$123	$144	$198	$252

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

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Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2014 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1)
October 2014	592,852	$128.37	592,852	$1,889,450,517
November 2014	3,236,801	130.97	3,236,801	1,365,543,163
December 2014	0	0	0	1,365,543,163
Total	3,829,653	$130.56	3,829,653	

(1) In September 2014, the Board of Directors replaced a previous share repurchase authorization of up to $1 billion with a current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Under the current share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment bankers), subject to certain regulatory restrictions on volume, pricing, and timing. As of February 18, 2015, the remaining authorized amount under the current authorization totaled approximately $1.37 billion, which includes $100 million of stock held back as part of an accelerated share repurchase agreement as more fully described under "Stock Repurchases" in Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(2) Excludes 0.02 million shares repurchased in connection with employee stock plans.

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ITEM 6. SELECTED FINANCIAL DATA

	2014 (a)	2013 (b)	2012 (c)	2011	2010 (d)
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$45,959	$38,829	$37,009	$35,106	$32,712
Services	2,164	2,109	1,726	1,360	555
Investment income	377	375	391	366	329
Total revenues	48,500	41,313	39,126	36,832	33,596
Operating expenses:					
Benefits	38,166	32,564	30,985	28,823	27,117
Operating costs	7,639	6,355	5,830	5,395	4,380
Depreciation and amortization	333	333	295	270	245
Total operating expenses	46,138	39,252	37,110	34,488	31,742
Income from operations	2,362	2,061	2,016	2,344	1,854
Interest expense	192	140	105	109	105
Income before income taxes	2,170	1,921	1,911	2,235	1,749
Provision for income taxes	1,023	690	689	816	650
Net income	$1,147	$1,231	$1,222	$1,419	$1,099
Basic earnings per common share	$7.44	$7.81	$7.56	$8.58	$6.55
Diluted earnings per common share	$7.36	$7.73	$7.47	$8.46	$6.47
Dividends declared per common share	$1.11	$1.07	$1.03	$0.75	$—
Financial Position:					
Cash and investments	$11,482	$10,938	$11,153	$10,830	$10,046
Total assets	23,466	20,735	19,979	17,708	16,103
Benefits payable	4,475	3,893	3,779	3,754	3,469
Debt	3,825	2,600	2,611	1,659	1,669
Stockholders’ equity	9,646	9,316	8,847	8,063	6,924
Cash flows from operations	$1,618	$1,716	$1,923	$2,079	$2,242
Key Financial Indicators:					
Benefit ratio	83.0 %	83.9 %	83.7 %	82.1 %	82.9 %
Operating cost ratio	15.9 %	15.5 %	15.1 %	14.8 %	13.2 %
Membership by Segment:					
Retail segment:					
Medical membership	7,882,300	6,026,000	5,553,800	4,795,000	3,681,900
Specialty membership	1,165,800	1,042,500	948,700	782,500	510,000
Employer Group segment:					
Medical membership	2,834,000	2,833,100	2,852,400	2,794,900	3,009,500
Specialty membership	6,502,700	6,780,800	7,136,200	6,532,600	6,517,500
Other Businesses:					
Medical membership	3,125,400	3,125,200	3,682,600	3,594,700	3,595,200
Consolidated:					

Total medical membership	13,841,700	11,984,300	12,088,800	11,184,600	10,286,600
Total specialty membership	7,668,500	7,823,300	8,084,900	7,315,100	7,027,500

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

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

(c) Includes the acquired operations of Arcadian Management Services, Inc. from March 31, 2012, SeniorBridge Family Companies, Inc. from July 6, 2012, and Metropolitan Health Networks, Inc. from December 21, 2012. Includes the acquired operations of Concentra Inc. from December 21, 2010. Also includes operating costs of $147 million ($93 million after tax, or $0.55 per diluted common share) for the write-down of deferred acquisition costs

(d) associated with our individual commercial medical policies and benefits expense of $139 million ($88 million after tax, or $0.52 per diluted common share) associated with reserve strengthening for our non-strategic closed block of long-term care insurance policies.

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

Executive Overview

General

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

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

Business Segments

On January 1, 2014, we reclassified certain of our businesses from our Healthcare Services segment to our Employer Group segment to correspond with internal management reporting changes. Our reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. This is further described in Note 2 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

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

The Retail segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, marketed directly to individuals, and includes our contract with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Employer Group segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary benefit products, as well as administrative services only, or ASO, products and our health and wellness products primarily marketed to employer groups. The Healthcare Services segment includes services offered to our health plan members as well as to third parties including pharmacy solutions, provider services, home based services, integrated behavioral health services, and predictive modeling and informatics services. The Other Businesses category consists of our military services, primarily our TRICARE South Region contract, Puerto Rico Medicaid, and closed-block long-term care insurance policies.

The results of each segment are measured by income before income taxes. Transactions between reportable segments consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, home based, and behavioral health, to our Retail and Employer Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often utilize the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent.

We 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

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expense on corporate debt, and certain other corporate expenses. These items are managed at the corporate level. These corporate amounts are reported separately from our reportable segments and included with intersegment eliminations.

Seasonality

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

Our Employer Group segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Employer Group's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses. Similarly, certain of our fully-insured individual commercial medical products in our Retail segment experience seasonality in the benefit ratio akin to the Employer Group segment, including the effect of existing members transitioning to policies compliant with the Health Care Reform Law.

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

2014 Highlights

Consolidated

Our 2014 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. A core element of the model is to offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. 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. At December 31, 2014, approximately 709,000 members, or 29.0%, of our individual Medicare Advantage membership were in risk arrangements under our integrated care delivery model, as compared to 561,500 members, or 27.1%, at December 31, 2013.

- Year-over-year comparisons of our results were impacted by investments in health care exchanges and state-based contracts as well as higher specialty prescription drug costs associated with a new treatment for Hepatitis C, partially offset by membership growth in our Medicare Advantage, Medicare stand-alone PDP, and individual commercial medical offerings as well as increased membership in our clinical programs.
- In September 2014, we paid the federal government $562 million for the annual health insurance industry fee. This fee is not deductible for tax purposes, which has significantly increased our effective income tax rate in 2014. Year-over-year comparisons of the operating cost ratio are negatively impacted by this and other fees mandated by the Health Care Reform Law beginning in 2014. Likewise, year-over-year comparisons of the benefit ratio reflect the inclusion of these mandated fees in the pricing of our products for 2014. In 2015, the health insurance industry fee

increases by 41% for the industry taken as a whole. Accordingly, absent changes in market share, we would expect a 41% increase in our fee in 2015. The health insurance industry fee is further described below under the section titled "Health Care Reform."

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- Year-over-year comparisons of diluted earnings per common share are favorably impacted by a lower number of shares used to compute diluted earnings per common share reflecting the impact of share repurchases.
- Our operating cash flow of $1.6 billion for the year ended December 31, 2014 compared to operating cash flow of $1.7 billion for the year ended December 31, 2013. For 2014, the effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law impacted the timing of our operating cash flows, as we built a receivable of $679 million in 2014 that is expected to be collected in 2015.
- Our 2014 financing cash flows have been negatively impacted by the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies for which we do not assume risk. Claims payments were $945 million higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk during 2014. We are experiencing higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which is resulting in higher reinsurance subsidy receivable balances in 2014 that will be settled in 2015 under the terms of our contracts with CMS.
- We continue to focus on disciplined capital allocation. In 2014, we issued senior notes and received net proceeds of $1.7 billion, redeemed our $500 million 6.45% senior notes for cash totaling approximately $560 million, repurchased 5.7 million shares of our common stock for $730 million in open market transactions (which excludes another $100 million of stock held back pursuant to an accelerated share repurchase program), and paid dividends to stockholders of $172 million.

Retail Segment

- On April 7, 2014, CMS announced final 2015 Medicare benchmark payment rates and related technical factors impacting the bid benchmark premiums, which we refer to as the Final Rate Notice. We believe the Final Rate Notices together with the impact of payment cuts associated with the Health Care Reform Law, quality bonuses, sunset of the Star quality CMS demonstration in 2015, risk coding modifications, the impact of the health insurance industry fee, and other funding formula changes, indicate 2015 Medicare Advantage funding cuts of approximately 2%. We believe we have effectively designed Medicare Advantage products based upon these levels of rate reduction while continuing to remain competitive compared to both the combination of Medicare FFS with a supplement policy as well as Medicare Advantage products offered by our competitors. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.
- Medicare Advantage premiums are tied to the achievement of certain quality performance measures (Star Ratings). Beginning in 2015, plans must have a Star Rating of four or higher to qualify for bonus money. Star Ratings issued by CMS in October 2014 indicated that plans covering 92% of our Medicare Advantage membership for the 2015 plan year achieved a Star Rating of 4.0 or higher. We have 23 Medicare Advantage plans that achieved a rating of four or more stars, an increase from 18 the previous year. We are offering one Medicare Advantage plan that achieved a 5.0 Star Rating, our CarePlus Health Plans, Inc. HMO plan in Florida, as well as five Medicare Advantage plans that achieved a 4.5 Star Rating. Plans that earn an overall Star Rating of five become eligible to enroll members year round.
- As discussed in the detailed Retail segment results of operations discussion that follows, for the year ended December 31, 2014, our Retail segment pretax income declined by 14.4% primarily due to the same factors discussed above for our consolidated results.
- Individual Medicare Advantage membership increased 377,500 members, or 18.2%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, particularly for our HMO offerings, for the 2014 plan year as well as dual eligible members from state-based contracts in Virginia and Illinois. January 1, 2015 individual Medicare Advantage membership increased approximately 257,000 members, or 10.5%, from December 31, 2014 reflecting net membership additions for the 2015 enrollment season, primarily in our HMO offerings.

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- Medicare stand-alone PDP membership increased 717,800 members, or 21.9%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2014 plan year. January 1, 2015 Medicare stand-alone PDP membership, excluding the LI-NET prescription drug plan program, increased approximately 230,500 members, or 5.8%, from December 31, 2014 reflecting net membership additions for the 2015 enrollment season.
- Our state-based Medicaid membership as of December 31, 2014 increased 213,000 members from December 31, 2013, primarily due to the addition of members under our Florida Medicaid and Florida Long-Term Support Services contracts.
- Individual commercial medical membership of 1,148,100 at December 31, 2014 increased 548,000 members, or 91.3%, from December 31, 2013 primarily reflecting new sales, both on-exchange and off-exchange, of plans compliant with the Health Care Reform Law. At December 31, 2014, individual commercial medical membership in plans compliant with the Health Care Reform Law, both on-exchange and off-exchange, was 686,300 members. In addition, federal and state regulatory changes in December 2013 allowed certain individuals to remain in their existing underwritten health plans that are not compliant with the Health Care Reform Law, which has led to much higher than previously expected retention of our existing underwritten health plans. We believe that this is occurring at other health insurance issuers as well and will result in an overall deterioration of the risk pool in plans compliant with the Health Care Reform Law, as more previously underwritten members remain with their current health plans rather than enter the exchanges. However, we expect that the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law will mitigate this deterioration to some extent.

Employer Group Segment

- As discussed in the detailed Employer Group segment results of operations discussion that follows, the Employer Group segment pretax income declined 10.3% for the year ended December 31, 2014 primarily reflecting higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes which allowed individuals to remain in plans not compliant with the Health Care Reform Law.
- Fully-insured group Medicare Advantage membership of 489,700 at December 31, 2014 increased 60,600 members, or 14.1%, from 429,100 at December 31, 2013 primarily due to the January 2014 addition of a new large group account.
- Membership in HumanaVitality®, our wellness and loyalty rewards program, rose 36.2% to 3,856,800 at December 31, 2014 from 2,831,000 at December 31, 2013 primarily due to the addition of group Medicare members as well as individual Medicare Advantage and fully-insured individual commercial medical membership growth.

Healthcare Services Segment

- As discussed in the detailed Healthcare Services segment results of operations discussion that follows, our Healthcare Services segment pretax income improved 41.8% for the year ended December 31, 2014 primarily due to a decline in the operating cost ratio in 2014 on a revenue base that reflects growth from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.
- Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We have accelerated our process for identifying and reaching out to members in need of clinical intervention. At December 31, 2014, we had approximately 420,700 members with complex chronic conditions in the Humana Chronic Care Program, a 50.1% increase compared with approximately 280,200 members at December 31, 2013, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

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Other Businesses

Year-over-year comparisons within Other Businesses are impacted by the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 and a reduction in benefits expense in 2013 related to a favorable settlement of contract claims with the United States Department of Defense, or DoD, associated with previously disclosed litigation. In addition, as discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, during 2013, we recorded net benefits expense of $243 million ($154 million after-tax, or $0.99 per diluted common share) for reserve strengthening related to our non-strategic closed-block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Implementation dates of the Health Care Reform Law began in September 2010 and will continue through 2018, and many aspects of the Health Care Reform Law are already effective and have been implemented by us. 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, an annual insurance industry premium-based assessment, and a three-year commercial reinsurance fee. Certain provisions of the Health Care Reform Law became effective in 2014, including:

- All individual and group health plans must guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments;
- The elimination of annual limits on coverage on certain benefits;
- The establishment of federally-facilitated, federal-state partnerships or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers;
- The introduction of plan designs based on set actuarial values;
- The establishment of a minimum benefit ratio of 85% for Medicare Advantage plans with penalties up to and including termination of Medicare Advantage contracts for continued failure to meet the minimum; and
- Insurance industry assessments, including an annual health insurance industry fee and a three-year $25 billion industry wide commercial reinsurance fee. The annual health insurance industry fee levied on the insurance industry is $8 billion in 2014 with increasing annual amounts thereafter, growing to $14 billion by 2017, and is not deductible for income tax purposes, which significantly increased our effective income tax rate in 2014 to approximately 47.2%. In 2014, we paid the federal government $562 million for the annual health insurance industry fee. In 2015, the health insurance industry fee increases by 41% for the industry taken as a whole. Accordingly, absent changes in market share, we would expect a 41% increase in our fee in 2015. In addition, statutory accounting for the health insurance industry fee required us to restrict surplus in the year preceding payment of the health insurance industry fee beginning in 2014. Accordingly, in addition to recording the full-year 2014 assessment in the first quarter of 2014, we were required to restrict surplus for the 2015 assessment ratably in 2014.

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The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). In addition, the Health Care Reform Law has increased and will continue to increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms comes, in part, from material additional fees and taxes on us (as discussed above) and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described in this report.

As discussed above, it is reasonably possible that the Health Care Reform Law and related regulations, as well as future legislative changes, including legislative restrictions on our ability to manage our provider network or otherwise operate our business, or regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with the non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows (including the receipt of amounts due under the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law in 2015 related to claims paid in 2014, which payments may be subject to federal administrative action).

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 behavioral health services, to our Retail and Employer Group customers and are described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

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Comparison of Results of Operations for 2014 and 2013

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

Consolidated

	2014	2013	Change Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$33,954	$27,204	$6,750	24.8 %
Employer Group	11,935	10,930	1,005	9.2 %
Other Businesses	70	695	(625)	(89.9)%
Total premiums	45,959	38,829	7,130	18.4 %
Services:				
Retail	39	16	23	143.8 %
Employer Group	362	359	3	0.8 %
Healthcare Services	1,282	1,280	2	0.2 %
Other Businesses	481	454	27	5.9 %
Total services	2,164	2,109	55	2.6 %
Investment income	377	375	2	0.5 %
Total revenues	48,500	41,313	7,187	17.4 %
Operating expenses:				
Benefits	38,166	32,564	5,602	17.2 %
Operating costs	7,639	6,355	1,284	20.2 %
Depreciation and amortization	333	333	—	— %
Total operating expenses	46,138	39,252	6,886	17.5 %
Income from operations	2,362	2,061	301	14.6 %
Interest expense	192	140	52	37.1 %
Income before income taxes	2,170	1,921	249	13.0 %
Provision for income taxes	1,023	690	333	48.3 %
Net income	$1,147	$1,231	$(84)	(6.8)%
Diluted earnings per common share	$7.36	$7.73	$(0.37)	(4.8)%
Benefit ratio (a)	83.0 %	83.9 %		(0.9)%
Operating cost ratio (b)	15.9 %	15.5 %		0.4 %
Effective tax rate	47.2 %	35.9 %		11.3 %

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

(b) Represents total operating costs as a percentage of total revenues less investment income.

Summary

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

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includes benefits expense of $0.99 per diluted common share for reserve strengthening associated with our closed-block of long-term care insurance policies included with Other Businesses as discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data as well as the benefit of a reduction in benefits expense in 2013 related to a favorable settlement of contract claims with the DoD. Excluding these items, the increase in net income primarily resulted from higher pretax income in our Healthcare Services segment substantially offset by lower pretax income in our Retail and Employer Group segments. In addition, 2014 was favorably impacted by a lower number of shares used to compute diluted earnings per common share reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $7.1 billion, or 18.4%, from 2013 to $46.0 billion for 2014 primarily due to increases in both Retail and Employer Group segment premiums mainly driven by higher average individual and group Medicare Advantage membership as well as higher individual commercial medical membership. In addition, year-over-year comparisons to the 2013 were negatively impacted by sequestration which became effective April 1, 2013. Premiums revenue for our Other Businesses declined primarily due to the loss of our Puerto Rico Medicaid contracts effective September 30, 2013. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per member premiums. Items impacting average per member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Services Revenue

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

Investment Income

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

Benefits Expense

Consolidated benefits expense was $38.2 billion for 2014, an increase of $5.6 billion, or 17.2%, from 2013 primarily due to increases in both the Retail and Employer Group segments mainly driven by higher average individual and group Medicare Advantage membership as well as higher individual commercial medical membership. As more fully described herein under the section entitled “Benefits Expense Recognition”, actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $518 million in 2014 and $474 million in 2013. These increases in favorable medical claims reserve development primarily resulted from increased membership and better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

The consolidated benefit ratio for 2014 was 83.0%, a decrease of 90 basis points from 2013 primarily due to reserve strengthening in 2013 associated with our closed-block of long-term care insurance policies included with Other Businesses as discussed above, as well as the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 which more than offset higher ratios year-over-year in the Retail and Employer Group segments.

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Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent. Consolidated operating costs increased $1,284 million, or 20.2%, in 2014 compared to 2013 primarily due to costs mandated by the Health Care Reform Law, including the non-deductible health insurance industry fee, and investments in health care exchanges and state-based contracts, partially offset by operating cost efficiencies.

The consolidated operating cost ratio for 2014 was 15.9%, increasing 40 basis points from 2013 primarily due to increases in the operating cost ratios in our Retail and Employer Group segments due to the same factors impacting consolidated operating costs as described above.

Depreciation and Amortization

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

Interest Expense

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

Income Taxes

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

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Retail Segment

	2014	2013	Change Members	Percentage	
Membership:					
Medical membership:					
Individual Medicare Advantage	2,446,200	2,068,700	377,500	18.2	%
Medicare stand-alone PDP	3,989,500	3,271,700	717,800	21.9	%
Total Retail Medicare	6,435,700	5,340,400	1,095,300	20.5	%
Individual commercial (a)	1,148,100	600,100	548,000	91.3	%
State-based Medicaid	298,500	85,500	213,000	249.1	%
Total Retail medical members	7,882,300	6,026,000	1,856,300	30.8	%
Individual specialty membership (b)	1,165,800	1,042,500	123,300	11.8	%

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

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

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

	2014 (in millions)	2013	Change Dollars	Percentage	
Premiums and Services Revenue:					
Premiums:					
Individual Medicare Advantage	$25,941	$22,481	$3,460	15.4	%
Medicare stand-alone PDP	3,396	3,025	371	12.3	%
Total Retail Medicare	29,337	25,506	3,831	15.0	%
Individual commercial	3,265	1,160	2,105	181.5	%
State-based Medicaid	1,096	328	768	234.1	%
Individual specialty	256	210	46	21.9	%
Total premiums	33,954	27,204	6,750	24.8	%
Services	39	16	23	143.8	%
Total premiums and services revenue	$33,993	$27,220	$6,773	24.9	%
Income before income taxes	$1,098	$1,283	$(185)	(14.4)	%
Benefit ratio	84.3 %	84.2 %		0.1	%
Operating cost ratio	12.4 %	10.9 %		1.5	%

Pretax Results

- Retail segment pretax income was $1.1 billion in 2014, a decrease of $185 million, or 14.4%, compared to 2013 primarily driven by investment spending for health care exchanges and state-based contracts and higher specialty prescription drug costs associated with a new treatment for Hepatitis C, partially offset by Medicare Advantage and individual commercial medical membership growth as well as increased membership in our clinical programs.

Enrollment

- Individual Medicare Advantage membership increased 377,500 members, or 18.2%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, particularly for our HMO offerings, for the 2014

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plan year as well as dual eligible members from state-based contracts in Virginia and Illinois. Individual Medicare Advantage membership at December 31, 2014 includes 18,300 dual eligible members from state-based contracts.

- Medicare stand-alone PDP membership increased 717,800 members, or 21.9%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2014 plan year.
- Individual commercial medical membership increased 548,000 members, or 91.3%, from December 31, 2013 to December 31, 2014 primarily reflecting new sales, both on-exchange and off-exchange, of plans compliant with the Health Care Reform Law.
- State-based Medicaid membership increased 213,000 members, or 249.1%, from December 31, 2013 to December 31, 2014 primarily driven by the addition of members under our Florida Medicaid and Florida Long-Term Support Services contracts.
- Individual specialty membership increased 123,300 members, or 11.8%, from December 31, 2013 to December 31, 2014 primarily driven by increased membership in dental and vision offerings.

Premiums revenue

- Retail segment premiums increased $6.8 billion, or 24.8%, from 2013 to 2014 primarily due to membership growth across all lines of business, particularly for our individual Medicare Advantage, individual commercial medical, primarily on the health care exchanges, and state-based Medicaid businesses. Individual Medicare Advantage average membership increased 17.0% in 2014. Individual Medicare Advantage per member premiums decreased approximately 1.4% in 2014 compared to 2013, primarily due to Medicare rate reductions and the impact of sequestration which became effective on April 1, 2013.

Benefits expense

- The Retail segment benefit ratio of 84.3% for 2014 increased 10 basis points from 2013 primarily due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, higher planned clinical investment spending, and higher benefit ratios associated with members from state-based contracts, partially offset by increased membership in our clinical programs and the inclusion of the health insurance industry fee in the pricing of our products.
- The Retail segment's benefits expense for 2014 included the beneficial effect of $385 million in favorable prior-year medical claims reserve development versus $332 million in 2013. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 110 basis points in 2014 versus approximately 120 basis points in 2013.

Operating costs

- The Retail segment operating cost ratio of 12.4% for 2014 increased 150 basis points from 2013 primarily due to the non-deductible health insurance industry fee mandated by the Health Care Reform Law and investment spending for health care exchanges and state-based contracts, partially offset by scale efficiencies from Medicare and individual commercial medical membership growth.

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Employer Group Segment

	2014	2013	Change Members	Percentage
Membership:				
Medical membership:				
Group Medicare Advantage	489,700	429,100	60,600	14.1 %
Group Medicare stand-alone PDP	4,500	4,200	300	7.1 %
Total group Medicare	494,200	433,300	60,900	14.1 %
Fully-insured commercial group	1,235,500	1,237,000	(1,500)	(0.1)%
ASO	1,104,300	1,162,800	(58,500)	(5.0)%
Total group medical members	2,834,000	2,833,100	900	— %
Group specialty membership (a)	6,502,700	6,780,800	(278,100)	(4.1)%

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

	2014 (in millions)	2013	Change Dollars	Percentage
Premiums and Services Revenue:				
Premiums:				
Group Medicare Advantage	$5,490	$4,710	$780	16.6 %
Group Medicare stand-alone PDP	8	8	—	— %
Total group Medicare	5,498	4,718	780	16.5 %
Fully-insured commercial group	5,339	5,117	222	4.3 %
Group specialty	1,098	1,095	3	0.3 %
Total premiums	11,935	10,930	1,005	9.2 %
Services	362	359	3	0.8 %
Total premiums and services revenue	$12,297	$11,289	$1,008	8.9 %
Income before income taxes	$314	$350	$(36)	(10.3)%
Benefit ratio	83.9 %	83.5 %		0.4 %
Operating cost ratio	16.1 %	15.9 %		0.2 %

Pretax Results

- Employer Group segment pretax income decreased $36 million, or 10.3%, to $314 million in 2014 primarily reflecting higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes which allowed individuals to remain in plans not compliant with the Health Care Reform Law.

Enrollment

- Fully-insured group Medicare Advantage membership increased 60,600 members, or 14.1%, from December 31, 2013 to December 31, 2014 primarily due to the addition of a new large group account.
- Fully-insured commercial group medical membership decreased 1,500 members, or 0.1% from December 31, 2013 as an increase in small group business membership was generally offset by lower membership in large

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group accounts. Approximately 65% of our fully-insured commercial group medical membership was in small group accounts at December 31, 2014 compared to 61% at December 31, 2013.

- Group ASO commercial medical membership decreased 58,500 members, or 5.0%, from December 31, 2013 to December 31, 2014 primarily due to continued pricing discipline in a highly competitive environment for self-funded accounts. We expect our group ASO commercial medical membership to decline by approximately 400,000 to 425,000 members January 1, 2015 primarily due to the loss of a few large group accounts.
- Group specialty membership decreased 278,100 members, or 4.1%, from December 31, 2013 to December 31, 2014 primarily due to declines in dental and vision membership related to our planned discontinuance of certain unprofitable product distribution partnerships.

Premiums revenue

- Employer Group segment premiums increased $1.0 billion, or 9.2%, from 2013 to 2014 primarily due to higher average group Medicare Advantage membership as well as an increase in fully-insured commercial group medical premiums per member that more than offset a slight decline in total membership for this segment.

Benefits expense

- The Employer Group segment benefit ratio increased 40 basis points from 83.5% in 2013 to 83.9% in 2014 primarily due to higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes, partially offset by the inclusion of the health insurance industry fee and other fees mandated by the Health Care Reform Law in our pricing.
- The Employer Group segment’s benefits expense included the beneficial effect of $132 million in favorable prior-year medical claims reserve development versus $138 million in 2013. This favorable prior-year medical claims reserve development decreased the Employer Group segment benefit ratio by approximately110 basis points in 2014 versus approximately 130 basis points in 2013.

Operating costs

- The Employer Group segment operating cost ratio of 16.1% increased 20 basis points from 2013. This increase primarily reflects the impact of the non-deductible health insurance industry fee and other fees mandated by the Health Care Reform Law as well as a higher percentage of small group commercial business which carries a higher operating cost ratio than large group business. These increases were partially offset by an increase in group Medicare Advantage membership which generally carries a lower operating cost ratio than our commercial group medical membership as well as operating cost efficiencies.

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Healthcare Services Segment

	2014	2013	Change Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Provider services	$1,076	$1,125	$(49)	(4.4)%
Home based services	107	94	13	13.8 %
Pharmacy solutions	99	59	40	67.8 %
Integrated behavioral health services	—	2	(2)	(100.0)%
Total services revenues	1,282	1,280	2	0.2 %
Intersegment revenues:				
Pharmacy solutions	16,905	13,079	3,826	29.3 %
Provider services	1,110	1,080	30	2.8 %
Home based services	585	326	259	79.4 %
Integrated behavioral health services	133	126	7	5.6 %
Total intersegment revenues	18,733	14,611	4,122	28.2 %
Total services and intersegment revenues	$20,015	$15,891	$4,124	26.0 %
Income before income taxes	$739	$521	$218	41.8 %
Operating cost ratio	95.5 %	95.8 %		(0.3)%

Pretax results

- Healthcare Services segment pretax income of $739 million for 2014 increased $218 million from 2013. The increase is primarily due to a decline in the operating cost ratio in 2014 on a revenue base that reflects growth from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.

Script Volume

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

Services revenue

- Services revenue for 2014 were relatively unchanged from 2013, increasing $2 million, or 0.2% , to $1.3 billion for 2014.

Intersegment revenues

- Intersegment revenues increased $4.1 billion, or 28.2%, from 2013 to $18.7 billion for 2014 primarily due to growth in our Medicare membership which resulted in higher utilization of our pharmacy solutions and home based services businesses.

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Operating costs

The Healthcare Services segment operating cost ratio of 95.5% for 2014 decreased 30 basis points from 95.8% for 2013 primarily due to an improvement in the ratio for our pharmacy solutions business partially offset by our investment in home based services and other businesses across the segment.

Other Businesses

Our Other Businesses pretax income of $78 million for 2014 compared to a pretax loss of $193 million for 2013. The pretax loss in 2013 included net expense of $243 million for reserve strengthening for our closed-block of long-term care insurance policies further discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives. Among the businesses that we are currently evaluating is our closed block of long-term care insurance policies business. While no decision has been made with respect to any course of action, if we were to divest this business it is reasonably likely that we would have to recognize a material loss that will have a material adverse effect on our results of operations. Year-over-year comparisons also reflect the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 as well as a reduction in benefits expense in 2013 related to a favorable settlement of contract claims with the DoD associated with previously disclosed litigation.

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Comparison of Results of Operations for 2013 and 2012

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2013 and 2012:

Consolidated

	2013	2012	Change Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$27,204	$25,001	$2,203	8.8 %
Employer Group	10,930	10,138	792	7.8 %
Other Businesses	695	1,870	(1,175)	(62.8)%
Total premiums	38,829	37,009	1,820	4.9 %
Services:				
Retail	16	24	(8)	(33.3)%
Employer Group	359	371	(12)	(3.2)%
Healthcare Services	1,280	1,023	257	25.1 %
Other Businesses	454	308	146	47.4 %
Total services	2,109	1,726	383	22.2 %
Investment income	375	391	(16)	(4.1)%
Total revenues	41,313	39,126	2,187	5.6 %
Operating expenses:				
Benefits	32,564	30,985	1,579	5.1 %
Operating costs	6,355	5,830	525	9.0 %
Depreciation and amortization	333	295	38	12.9 %
Total operating expenses	39,252	37,110	2,142	5.8 %
Income from operations	2,061	2,016	45	2.2 %
Interest expense	140	105	35	33.3 %
Income before income taxes	1,921	1,911	10	0.5 %
Provision for income taxes	690	689	1	0.1 %
Net income	$1,231	$1,222	$9	0.7 %
Diluted earnings per common share	$7.73	$7.47	$0.26	3.5 %
Benefit ratio (a)	83.9 %	83.7 %		0.2 %
Operating cost ratio (b)	15.5 %	15.1 %		0.4 %
Effective tax rate	35.9 %	36.1 %		(0.2)%

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

(b) Represents total operating costs as a percentage of total revenues less investment income.

Summary

Net income was $1.2 billion, or $7.73 per diluted common share, in 2013 compared to $1.2 billion, or $7.47 per diluted common share, in 2012. The increase in net income primarily was driven by improved operating performance across most of our major business lines, including Medicare Advantage membership growth in our Retail and Employer

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group segments. These increases were partially offset by benefits expense of $0.99 per diluted common share in 2013 for reserve strengthening associated with our closed-block of long-term care insurance policies included with Other Businesses as discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. Year-over-year comparisons of diluted earnings per common share are favorably impacted by a lower number of shares used to compute diluted earnings per common share in 2013 reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $1.8 billion, or 4.9%, from 2012 to $38.8 billion for 2013 primarily due to increases in both Retail and Employer Group segment premiums mainly driven by higher average individual and group Medicare Advantage membership, partially offset by the impact of sequestration which became effective April 1, 2013 as well as a decline in premiums for Other Businesses. The decline in premiums for Other Businesses primarily reflects the transition to the current TRICARE South Region contract effective April 1, 2012, and the termination of the Puerto Rico Medicaid contracts effective September 30, 2013. As discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, on April 1, 2012, we began delivering services under the current TRICARE South Region contract that the DHA awarded to us on February 25, 2011. We account for revenues under the current contract net of estimated healthcare costs similar to an administrative services fee only agreement, and as such there are no premiums recognized under the current contract. Our previous contract was accounted for similar to our fully-insured products and as such we recognized premiums under the previous contract.

Services Revenue

Consolidated services revenue increased $383 million, or 22.2%, from 2012 to $2.1 billion for 2013 primarily due to an increase in services revenue in our Healthcare Services segment and an increase in services revenue for our Other Businesses due to the transition to the current TRICARE South Region contract on April 1, 2012. The increase in services revenue in our Healthcare Services segment primarily resulted from the acquisitions of Metropolitan on December 21, 2012 and SeniorBridge on July 6, 2012, and growth in our provider services operations.

Investment Income

Investment income totaled $375 million for 2013, a decrease of $16 million from 2012, as higher average invested balances were more than offset by lower interest rates and lower net realized capital gains year-over-year.

Benefits Expense

Consolidated benefits expense was $32.6 billion for 2013, an increase of $1.6 billion, or 5.1%, from 2012 primarily due to a year-over-year increase in the Retail and Employer Group segments benefits expense, mainly driven by an increase in the average number of Medicare members, partially offset by a decrease in benefits expense for Other Businesses in 2013. The decrease in benefits expense for Other Businesses primarily was due to the transition to the current administrative services only TRICARE South Region contract on April 1, 2012 and the termination of the Puerto Rico Medicaid contracts effective September 30, 2013. We do not record benefits expense under the current TRICARE South Region contract. Our previous contract was accounted for similarly to our fully-insured products and as such we recorded benefits expense under the previous contract. Retail segment benefits expense increased $1.9 billion, or 8.9%, from 2012 to 2013 primarily due to membership growth. 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 $474 million in 2013 and $257 million in 2012. These increases in favorable medical claims reserve development primarily resulted from claims trend for the prior year ultimately developing more favorably than originally expected across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from

claim audit process enhancements as well as increased volume of claim audits and expanded audit scope.
The consolidated benefit ratio for 2013 was 83.9%, an increase of 20 basis points from 2012 primarily due to reserve strengthening associated with our closed-block of long-term care insurance policies included with Other

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Businesses as discussed above, partially offset by the increase in favorable prior-year medical claims reserve development of $217 million from 2012 to 2013.

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 $525 million, or 9.0%, in 2013 compared to 2012 primarily due to an increase in operating costs in our Retail and Healthcare Services segments. The increase in the Retail segment primarily reflects investment spending for exchanges under the Health Care Reform Law and new state-based contracts as well as increased marketing spending for Medicare.

The consolidated operating cost ratio for 2013 was 15.5%, increasing 40 basis points from 2012. The impact of the current TRICARE South Region contract being accounted for as an administrative services fee only arrangement beginning April 1, 2012 was partially offset by improved operating leverage in our Retail and Employer Group segments.

Depreciation and Amortization

Depreciation and amortization for 2013 totaled $333 million, an increase of $38 million, or 12.9%, from 2012 primarily due to capital expenditures and depreciation and amortization associated with 2012 and 2013 acquisitions.

Interest Expense

Interest expense was $140 million for 2013 compared to $105 million for 2012, an increase of $35 million, or 33.3%. In December 2012, we issued $600 million of 3.15% senior notes due December 1, 2022 and $400 million of 4.625% senior notes due December 1, 2042.

Income Taxes

Our effective tax rate during 2013 was 35.9% compared to the effective tax rate of 36.1% in 2012. 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

	2013	2012	Change Members	Percentage	
Membership:					
Medical membership:					
Individual Medicare Advantage	2,068,700	1,927,600	141,100	7.3	%
Medicare stand-alone PDP	3,271,700	3,052,700	219,000	7.2	%
Total Retail Medicare	5,340,400	4,980,300	360,100	7.2	%
Individual commercial	600,100	521,400	78,700	15.1	%
State-based Medicaid	85,500	52,100	33,400	64.1	%
Total Retail medical members	6,026,000	5,553,800	472,200	8.5	%
Individual specialty membership (a)	1,042,500	948,700	93,800	9.9	%

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

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

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	2013	2012	Change Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$22,481	$20,788	$1,693	8.1 %
Medicare stand-alone PDP	3,025	2,853	172	6.0 %
Total Retail Medicare	25,506	23,641	1,865	7.9 %
Individual commercial	1,160	1,004	156	15.5 %
State-based Medicaid	328	185	143	77.3 %
Individual specialty	210	171	39	22.8 %
Total premiums	27,204	25,001	2,203	8.8 %
Services	16	24	(8)	(33.3)%
Total premiums and services revenue	$27,220	$25,025	$2,195	8.8 %
Income before income taxes	$1,283	$1,161	$122	10.5 %
Benefit ratio	84.2 %	84.2 %		— %
Operating cost ratio	10.9 %	11.1 %		(0.2)%

Pretax Results

- Retail segment pretax income was $1.3 billion in 2013, an increase of $122 million, or 10.5%, compared to 2012 primarily reflecting improved operating performance over the prior year. The improved operating performance primarily was driven by membership growth as well as a decrease in the operating cost ratio.

Enrollment

- Individual Medicare Advantage membership increased 141,100 members, or 7.3%, from December 31, 2012 to December 31, 2013 reflecting net membership additions for the 2013 enrollment season and sales to newly-eligible Medicare beneficiaries throughout the year. Effective January 1, 2013, we divested approximately 12,600 members acquired with Arcadian Management Services, Inc. in accordance with our previously disclosed agreement with the United States Department of Justice.
- Medicare stand-alone PDP membership increased 219,000 members, or 7.2%, from December 31, 2012 to December 31, 2013 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2013 enrollment season.
- Individual commercial medical membership increased 78,700 members, or 15.1%, from December 31, 2012 to December 31, 2013 primarily reflecting net new sales in 2013. On October 1, 2013, the initial open enrollment period began for plans effective January 1, 2014 offered through federally facilitated, federal-state partnerships or state-based exchanges for individuals and small employers (with up to 100 employees), including certain metropolitan areas in the 14 states where Humana has public exchange offerings.
- State-based Medicaid membership increased 33,400 members, or 64.1%, from December 31, 2012 to December 31, 2013, primarily driven by the addition of our Kentucky Medicaid contract and Florida Long-Term Support Services contracts, including American Eldercare.
- Individual specialty membership increased 93,800 members, or 9.9%, from December 31, 2012 to December 31, 2013 primarily driven by increased membership in dental and vision offerings.

Premiums revenue

- Retail segment premiums increased $2.2 billion, or 8.8%, from 2012 to 2013 primarily due to a 7.6% increase in average individual Medicare Advantage membership in 2013. Individual Medicare Advantage per member

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premiums increased approximately 0.5% in 2013 compared to 2012, primarily reflecting the impact of sequestration which became effective on April 1, 2013.

Benefits expense

The Retail segment benefit ratio of 84.2% for 2013 was comparable to that of 2012. The Retail segment's benefits expense for 2013 included the beneficial effect of $332 million in favorable prior-year medical claims reserve development versus $192 million in 2012. This change in favorable prior-year medical claims reserve development primarily was driven by claims trend for the prior year ultimately developing more favorably than originally expected and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 130 basis points in 2013 versus approximately 80 basis points in 2012.

Operating costs

The Retail segment operating cost ratio of 10.9% for 2013 decreased 20 basis points from 2012. This decrease reflects scale efficiencies associated with servicing higher year-over-year membership together with our continued focus on operating cost efficiencies, partially offset by investment spending for exchanges under the Health Care Reform Law and new state-based contracts as well as increased Medicare marketing spending.

Employer Group Segment

	2013	2012	Change Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,237,000	1,211,800	25,200	2.1 %
ASO	1,162,800	1,237,700	(74,900)	(6.1)%
Group Medicare Advantage	429,100	370,800	58,300	15.7 %
Medicare Advantage ASO	—	27,700	(27,700)	(100.0)%
Total group Medicare Advantage	429,100	398,500	30,600	7.7 %
Group Medicare stand-alone PDP	4,200	4,400	(200)	(4.5)%
Total group Medicare	433,300	402,900	30,400	7.5 %
Total group medical members	2,833,100	2,852,400	(19,300)	(0.7)%
Group specialty membership (a)	6,780,800	7,136,200	(355,400)	(5.0)%

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

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	2013	2012	Change Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$5,117	$4,996	$121	2.4 %
Group Medicare Advantage	4,710	4,064	646	15.9 %
Group Medicare stand-alone PDP	8	8	—	— %
Total group Medicare	4,718	4,072	646	15.9 %
Group specialty	1,095	1,070	25	2.3 %
Total premiums	10,930	10,138	792	7.8 %
Services	359	371	(12)	(3.2)%
Total premiums and services revenue	$11,289	$10,509	$780	7.4 %
Income before income taxes	$350	$312	$38	12.2 %
Benefit ratio	83.5 %	83.6 %		(0.1)%
Operating cost ratio	15.9 %	16.2 %		(0.3)%

Pretax Results

- Employer Group segment pretax income increased $38 million, or 12.2%, to $350 million in 2013 reflecting improved operating performance primarily due to group Medicare Advantage membership growth and lower benefit and operating cost ratios, as described below.

Enrollment

- Fully-insured commercial group medical membership increased 25,200 members, or 2.1% from December 31, 2012 as higher small group business membership was partially offset by lower membership in large group accounts. Approximately 61% of our fully-insured commercial group medical membership was in small group accounts at December 31, 2013 compared to 59% at December 31, 2012.
- Fully-insured group Medicare Advantage membership increased 58,300 members, or 15.7%, from December 31, 2012 to December 31, 2013 primarily due to the January 2013 addition of a new large group retirement account. Effective January 1, 2013 we lost our sole group Medicare Advantage ASO account which had 27,700 members at December 31, 2012.
- Group ASO commercial medical membership decreased 74,900 members, or 6.1%, from December 31, 2012 to December 31, 2013 primarily due to continued pricing discipline in a highly competitive environment for self-funded accounts.
- Group specialty membership decreased 355,400 members, or 5.0%, from December 31, 2012 to December 31, 2013 primarily due to a decline in vision membership related to our planned discontinuance of certain unprofitable product distribution partnerships.

Premiums revenue

- Employer Group segment premiums increased $792 million, or 7.8%, from 2012 to 2013 primarily due to higher average group Medicare Advantage medical membership.

Benefits expense

- The Employer Group segment benefit ratio decreased 10 basis points from 83.6% in 2012 to 83.5% in 2013 primarily due to higher favorable prior-year medical claims reserve development, partially offset by growth

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in our group Medicare Advantage products which generally carry a higher benefit ratio than our fully-insured commercial group products. The Employer Group segment's benefits expense included the beneficial effect of $138 million in favorable prior-year medical claims reserve development versus $48 million in 2012. The change in favorable prior-year medical claims reserve development from 2012 to 2013 primarily was driven by claims trend for the prior year ultimately developing more favorably than originally expected and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. This favorable prior-year medical claims reserve development decreased the Employer Group segment benefit ratio by approximately 130 basis points in 2013 versus approximately 50 basis points in 2012.

Operating costs

- The Employer Group segment operating cost ratio of 15.9% decreased 30 basis points from 2012. This decrease primarily reflects continued savings as a result of our operating cost reduction initiatives and growth in our group Medicare Advantage products which generally carry a lower operating cost ratio than our fully-insured commercial group products, partially offset by investment spending in technology capabilities.

Healthcare Services Segment

	2013	2012	Change Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Provider services	$1,125	$966	$159	16.5 %
Home based services	94	40	54	135.0 %
Pharmacy solutions	59	16	43	268.8 %
Integrated behavioral health services	2	1	1	100.0 %
Total services revenues	1,280	1,023	257	25.1 %
Intersegment revenues:				
Pharmacy solutions	13,079	11,352	1,727	15.2 %
Provider services	1,080	370	710	191.9 %
Home based services	326	167	159	95.2 %
Integrated behavioral health services	126	133	(7)	(5.3)%
Total intersegment revenues	14,611	12,022	2,589	21.5 %
Total services and intersegment revenues	$15,891	$13,045	$2,846	21.8 %
Income before income taxes	$521	$428	$93	21.7 %
Operating cost ratio	95.8 %	96.1 %		(0.3)%

Pretax results

- Healthcare Services segment pretax income of $521 million for 2013 increased $93 million from 2012 as revenue growth and the pretax income contribution from our home based services and pharmacy solutions businesses, as well as the acquisition of Metropolitan, were partially offset by previously-planned investment spending associated with the integration and build-out of provider practices. The growth in pretax income associated with our home based services business reflects the increase in home health services provided to our Medicare Advantage members.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Employer Group segment membership increased to approximately 274 million in 2013, up 15% versus scripts of approximately 238 million in 2012.

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The increase primarily reflects growth associated with higher average medical membership for 2013 than in 2012.

Services revenue

- Services revenue increased $257 million or 25.1% from 2012 to $1.3 billion for 2013 primarily due to the acquisitions of Metropolitan and SeniorBridge as well as growth in our provider services operations.

Intersegment revenues

- Intersegment revenues increased $2.6 billion, or 21.5%, from 2012 to $14.6 billion for 2013 primarily due to growth in our pharmacy solutions business as it serves our growing membership, particularly Medicare stand-alone PDP, and the acquisition of Metropolitan in the fourth quarter of 2012.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.8% for 2013 decreased 30 basis points from 96.1% for 2012 primarily due to scale efficiencies associated with growth in our pharmacy solutions business.

Other Businesses

Our Other Businesses pretax loss of $193 million for 2013 compared to a pretax loss of $18 million for 2012. The pretax losses in 2013 and 2012 included net expense of $243 million and $29 million, respectively, for reserve strengthening for our closed-block of long-term care insurance policies further discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. In addition, 2013 reflects the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 offset by the beneficial effect of a favorable settlement of contract claims with the DoD primarily associated with litigation settled in 2012.

Liquidity

Our primary sources of cash include 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 include disbursements for claims payments, operating costs, interest on borrowings, taxes, purchases of investment securities, acquisitions, capital expenditures, repayments on borrowings, dividends, and share repurchases. Because premiums generally are collected in advance of claim payments by a period of up to several months, our business normally should produce positive cash flows during periods of increasing premiums and enrollment. Conversely, cash flows would be negatively impacted during periods of decreasing premiums and enrollment. From period to period, our cash flows may also be affected by the timing of working capital items including taxes and assessments. The use of operating cash flows may be limited by regulatory requirements which require, among other items, that our regulated subsidiaries maintain minimum levels of capital and seek approval before paying dividends from the subsidiaries to the parent. Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by Departments of Insurance.

For 2014, the effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law, commonly referred to as the 3Rs, impacted the timing of our operating cash flows, as we built a receivable in 2014 that is expected to be collected in 2015. The net receivable balance associated with the 3Rs was $679 million at December 31, 2014. In addition, our 2014 financing cash flows have been negatively impacted by the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies for which we do not assume risk. We are experiencing higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which resulted in higher reinsurance subsidy receivables balances in 2014 that will be settled in 2015 under the terms of our contracts with CMS. Any amounts receivable or payable associated with these risk limiting programs and CMS subsidies may have an impact on regulated subsidiary liquidity, with any temporary shortfalls funded by the parent company.

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2014 Form 10-K.

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Cash and cash equivalents increased to $1.9 billion at December 31, 2014 from $1.1 billion at December 31, 2013. The change in cash and cash equivalents for the years ended December 31, 2014, 2013 and 2012 is summarized as follows:

	2014	2013	2012
	(in millions)		
Net cash provided by operating activities	$1,618	$1,716	$1,923
Net cash used in investing activities	(63)	(1,182)	(1,965)
Net cash used in financing activities	(758)	(702)	(29)
Increase (decrease) in cash and cash equivalents	$797	$(168)	$(71)

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in earnings, enrollment activity, and the timing of working capital items as discussed below. Cash flows were positively impacted by annual Medicare enrollment gains because premiums generally are collected in advance of claim payments by a period of up to several months. In addition, 2014 operating cash flows were impacted by lower earnings and increased receivables associated with the 3Rs, partially offset by an increase in benefits payable from growth in membership.

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

The detail of total net receivables was as follows at December 31, 2014, 2013 and 2012:

				Change		
	2014	2013	2012	2014	2013	2012
	(in millions)					
Medicare	$664	$576	$422	$88	$154	$86
Commercial and other	535	405	346	130	59	31
Military services	106	87	59	19	28	(409)
Allowance for doubtful accounts	(137)	(118)	(94)	(19)	(24)	(9)
Total net receivables	$1,168	$950	$733	218	217	(301)
Reconciliation to cash flow statement:						
Provision for doubtful accounts				32	37	26
Receivables from disposition (acquisition)				14	(3)	(51)
Change in receivables per cash flow statement resulting in cash from operations				$264	$251	$(326)

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

The increases in commercial and other receivables in 2014 and 2013 primarily are due to growth in the business. In addition, the increase in commercial and other receivables in 2014 is primarily due to the commercial risk adjustment provision of the Health Care Reform Law which became effective in 2014.

Military services receivables at December 31, 2014 and 2013 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our current TRICARE South Region contract. The $409 million decrease in military services receivables from December 31, 2011 to December 31, 2012 primarily resulted from the transition to our current TRICARE South Region contract which we account for similar to

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an administrative services fee only agreement. As such, beginning April 1, 2012, payments of the federal government's claims and related reimbursements for the current TRICARE South Region contract are classified with receipts (withdrawals) from contract deposits as a financing item in our consolidated statements of cash flows.

The detail of benefits payable was as follows at December 31, 2014, 2013 and 2012:

				Change		
	2014	2013	2012	2014	2013	2012
	(in millions)					
IBNR (1)	$3,254	$2,586	$2,552	$668	$34	$496
Reported claims in process (2)	475	381	315	94	66	(61)
Military services benefits payable (3)	—	—	4	—	(4)	(335)
Other benefits payable (4)	746	926	908	(180)	18	(75)
Total benefits payable	$4,475	$3,893	$3,779	582	114	25
Payables from acquisition				—	(5)	(66)
Change in benefits payable per cash flow statement resulting in cash from operations				$582	$109	$(41)

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

(2) 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) Military services benefits payable primarily represents the run-out of the claims liability associated with our previous TRICARE South Region contract that expired on March 31, 2012. A corresponding receivable for reimbursement by the federal government is included in the military services receivable in the previous receivables table.

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

The increase in benefits payable in 2014 primarily was due to an increase in IBNR, primarily as a result of Medicare Advantage and individual commercial membership growth, and an increase in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuate due to month-end cutoff. These items were partially offset by a decrease in amounts owed to providers under capitated and risk sharing arrangements primarily related to the disbursement of a portion of our Medicare risk adjustment collections under our contractual obligations associated with our risk sharing arrangements. The increase in benefits payable in 2013 primarily was due to an increase in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuate due to month-end cutoff, and an increase in IBNR, primarily as a result of Medicare Advantage membership growth. The increase in benefits payable in 2012 primarily was due to an increase in IBNR, primarily as a result of Medicare Advantage membership growth, partially offset by a $335 million decrease in the military services benefits payable due to the run-out of claims under the previous TRICARE South Region contract that expired on March 31, 2012, a decrease in the amounts owed to providers under capitated and risk sharing arrangements, and a decrease in the amounts due to our pharmacy benefit administrator which fluctuate due to month-end cutoff. Under the current TRICARE South Region contract effective April 1, 2012, the federal government retains the risk of the cost of health benefits and related benefit obligation as further described in Note 2 to the consolidated financial statements included in Item 8. –

Financial Statements and Supplementary Data.

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. As discussed previously, the timing of payments and receipts associated with these provisions impacted our operating cash

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flows as we built a receivable in 2014 that is expected to be collected in 2015. The net receivable balance associated with the 3Rs was approximately $679 million at December 31, 2014, including certain amounts recorded in receivables as noted above. In September 2014, we paid the federal government $562 million for the annual health insurance industry fee.

In addition to the timing of receipts for premiums and services revenues, payments of benefits expense, and amounts due under the risk limiting and health insurance industry fee provisions of the Health Care Reform Law, other working capital items impacting operating cash flows primarily resulted from the timing of payments for the Medicare Part D risk corridor provisions of our contracts with CMS and changes in the timing of the collection of pharmacy rebates.

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 $528 million in 2014, $441 million in 2013, and $410 million in 2012. Excluding acquisitions, we expect total capital expenditures in 2015 to be in a range of approximately $575 million to $625 million primarily reflecting increased spending associated with growth in our provider services and pharmacy businesses in our Healthcare Services segment.

Proceeds from sales and maturities of investment securities exceeded purchases by $411 million in 2014. These net proceeds were used to fund normal working capital needs due to an increase in receivables in 2014 that will be collected in 2015 associated with the 3Rs in addition to the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies, as discussed below. We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $592 million in 2013 and $320 million in 2012.

Cash consideration paid for acquisitions, net of cash acquired, was $18 million in 2014, $187 million in 2013, and $1.2 billion in 2012. Acquisitions in 2014 included health and wellness related acquisitions. Cash paid for acquisitions in 2013 primarily related to the American Eldercare and other health and wellness related acquisitions. In 2012, acquisitions included Metropolitan, Arcadian, SeniorBridge and other health and wellness and technology related acquisitions.

Cash Flow from Financing Activities

Claims payments were $945 million higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk during 2014, $155 million higher during 2013, and $341 million higher during 2012. As discussed previously, our 2014 financing cash flows have been negatively impacted by the timing of payments to and receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. We experienced higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which is resulting in higher subsidy receivable balances in 2014 that will be settled in 2015 under the terms of our contracts with CMS. Our net receivable for CMS subsidies and brand name prescription drug discounts was $1.7 billion at December 31, 2014 compared to $713 million at December 31, 2013. Refer to Note 6 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Under our current administrative services only TRICARE South Region contract that began April 1, 2012, reimbursements from the federal government equaled health care cost payments for which we do not assume risk in 2014. Health care cost payments were less than reimbursements by $5 million in 2013 and exceeded reimbursements by $56 million in 2012 due to the timing of such receipts. Receipts from HHS associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were $26 million higher than claims payments for

the year ended 2014. See Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for further description.

We repurchased 5.7 million shares for $730 million in 2014, which excludes another $100 million of stock held back pending final settlement of an accelerated stock repurchase plan, 5.8 million shares for $502 million in 2013, and

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6.3 million shares for $460 million in 2012 under share repurchase plans authorized by the Board of Directors. We also acquired common shares in connection with employee stock plans for an aggregate cost of $42 million in 2014, $29 million in 2013, and $58 million in 2012.

As discussed further below, we paid dividends to stockholders of $172 million in 2014, $168 million in 2013, and $165 million in 2012.

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

In December 2012, we issued $600 million of 3.15% senior notes due December 1, 2022 and $400 million of 4.625% senior notes due December 1, 2042. Our net proceeds, reduced for the discount and cost of the offering, were $990 million. We used the proceeds from the offering primarily to finance the acquisition of Metropolitan, including the retirement of Metropolitan’s indebtedness, and to pay related fees and expenses.

In March 2012, we repaid, without penalty, junior subordinated long-term debt of $36 million.

The remainder of the cash used in or provided by financing activities in 2014, 2013, and 2012 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2012, 2013, and 2014 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount (in millions)
2012	$1.02	$165
2013	$1.06	$167
2014	$1.10	$170

In October 2014, the Board declared a cash dividend of $0.28 per share that was paid on January 30, 2015 to stockholders of record on December 31, 2014, for an aggregate amount of $42 million. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

Stock Repurchase Authorization

In September 2014, the Board of Directors replaced its previously approved share repurchase authorization of up to $1 billion (of which $816 million remained unused) with the current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Under the current share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions (including pursuant to an accelerated share repurchase agreement with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. As of February 18, 2015, the remaining authorized amount under the current authorization totaled approximately $1.37 billion, after giving effect to the $500 million accelerated share repurchase program we entered into in November 2014 with Goldman, Sachs & Co.

Senior Notes

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds,

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reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem the $500 million 6.45% senior unsecured notes as discussed below.

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

Credit Agreement

Our 5-year $1.0 billion unsecured revolving credit agreement expires July 2018. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110 basis points, varies depending on our credit ratings ranging from 90 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 10 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $7.8 billion at December 31, 2014 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $9.6 billion and actual leverage ratio of 1.4:1, as measured in accordance with the credit agreement as of December 31, 2014. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2014, we had no borrowings outstanding under the credit agreement. We have outstanding letters of credit of $4 million issued under the credit agreement at December 31, 2014. No amounts have been drawn on these letters of credit. Accordingly, as of December 31, 2014, we had $996 million of remaining borrowing capacity under the credit agreement, none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

In October 2014, we entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time, with the aggregate face or principal amounts outstanding under the program at any time not to exceed $1 billion. The net proceeds of issuances have been and are expected to be used for general corporate purposes, including to repurchase shares of our common stock. The maximum principal amount of commercial paper borrowings outstanding at any one time during the year ended December 31, 2014 was $175 million. There were no outstanding borrowings at December 31, 2014.

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, 2014 was BBB+ according to

Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $750 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis

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points, or annual interest expense by $2 million, up to a maximum 100 basis points, or annual interest expense by $8 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, certain of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated insurance subsidiaries. Cash, cash equivalents, and short-term investments at the parent company increased to $1.4 billion at December 31, 2014 from $508 million at December 31, 2013 primarily due to net proceeds of $1.73 billion from the September 2014 issuance of senior notes, offset by the $560 million senior note redemption discussed above and share repurchases. Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by Departments of Insurance. Our subsidiaries paid dividends to the parent of $927 million in 2014, $967 million in 2013, and $1.2 billion in 2012. The declines in dividends to the parent in 2013 and 2014 primarily were a result of higher surplus requirements associated with premium growth. Refer to our parent company financial statements and accompanying notes in Schedule I – Parent Company Financial Information. Regulatory requirements, including subsidiary dividends to the parent, are discussed in more detail in the following section. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2015 is approximately $800 million in the aggregate.

In September 2014, we paid the federal government $562 million for the annual health insurance industry fee attributed to calendar year 2014, in accordance with the Health Care Reform Law. In 2015, the health insurance industry fee increases by 41% for the industry taken as a whole. Accordingly, absent changes in market share, we would expect a 41% increase in our fee in 2015.

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, 2014 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
	(in millions)				
Debt	$3,800	$—	$—	$1,200	$2,600
Interest (1)	2,753	187	369	294	1,903
Operating leases (2)	1,145	232	361	188	364
Purchase obligations (3)	175	95	64	16	—
Future policy benefits payable and other long-term liabilities (4)	2,708	78	398	231	2,001
Total	$10,581	$592	$1,192	$1,929	$6,868

(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 2027. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. An operating lease is a type of off-balance sheet arrangement. Assuming we acquired the asset, rather than leased such asset, we would have recognized a liability for the financing of these assets. See also Note 16 to the consolidated

financial statements included in Item 8. – Financial Statements and Supplementary Data.

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(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, 2014, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion 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 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 related primarily 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.

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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, 2014	Percentage of Total		December 31, 2013	Percentage of Total	
	(dollars in millions)					
IBNR	$3,254	72.7	%	$2,586	66.4	%
Reported claims in process	475	10.6	%	381	9.8	%
Other benefits payable	746	16.7	%	926	23.8	%
Total benefits payable	$4,475	100.0	%	$3,893	100.0	%

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 three 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 three 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 three 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 three 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

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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 three 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 three months. Each of these factors requires significant judgment by management.

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 three months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderate adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2014 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)			
1.40%	$(357)	(4.00)%	$(381)
1.20%	$(306)	(3.50)%	$(333)
1.00%	$(255)	(3.00)%	$(286)
0.80%	$(204)	(2.50)%	$(238)
0.60%	$(153)	(2.25)%	$(214)
0.40%	$(102)	(2.00)%	$(190)
0.20%	$(51)	(1.50)%	$(143)

(a) Reflects estimated potential changes in benefits payable at December 31, 2014 caused by changes in completion factors for incurred months prior to the most recent three months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2014 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent three months.

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

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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.

	2014	2013	2012
	(in millions)		
Balances at January 1	$3,893	$3,775	$3,415
Acquisitions	—	5	66
Incurred related to:			
Current year	38,641	32,711	30,198
Prior years	(518)	(474)	(257)
Total incurred	38,123	32,237	29,941
Paid related to:			
Current year	(34,357)	(29,103)	(26,738)
Prior years	(3,262)	(3,021)	(2,909)
Total paid	(37,619)	(32,124)	(29,647)
Reinsurance recoverable	78	—	—
Balances at December 31	$4,475	$3,893	$3,775

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					
	2014		2013		2012	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$(266)	(3.7)%	$(233)	(3.4)%	$(138)	(2.4)%
Completion factors	(252)	1.2 %	(241)	1.2 %	(119)	0.7 %
Total	$(518)		$(474)		$(257)	

(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 $518 million in 2014, $474 million in 2013, and $257 million in 2012. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2014, 2013, and 2012.

	Favorable Medical Claims Reserve Development			Change	
	2014	2013	2012	2014	2013
	(in millions)				
Retail Segment	$(385)	$(332)	$(192)	$(53)	$(140)
Employer Group Segment	(132)	(138)	(48)	6	(90)
Other Businesses	(1)	(4)	(17)	3	13
Total	$(518)	$(474)	$(257)	$(44)	$(217)

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The favorable medical claims reserve development for 2014, 2013, and 2012 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. In addition, the favorable medical claims reserve development during 2014 and 2013 reflects increased membership and better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements. 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, 2014 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense associated with military services and provisions associated with future policy benefits excluded from the previous table was as follows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
	(in millions)		
Military services	$11	$(27)	$908
Future policy benefits	32	354	136
Total	$43	$327	$1,044

Due to the transition to the current TRICARE South Region contract on April 1, 2012, which is accounted for as an administrative services only contract as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, there was no military services benefits payable at December 31, 2014 or 2013. This transition is also the primary reason for the decline in military services benefits expense from 2012 to 2013.

Future policy benefits payable of $2.3 billion and $2.2 billion at December 31, 2014 and 2013, respectively, represent liabilities for long-duration insurance policies including long-term care insurance, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs.

Future policy benefits payable include $1.5 billion at December 31, 2014 and $1.4 billion at December 31, 2013 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Approximately 32,700 policies remain in force as of December 31, 2014. No new policies have been written since 2005 under this closed block. Future policy benefits payable includes amounts charged to

accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was $123 million of additional liability at December 31, 2014 and no additional

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liability at December 31, 2013. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

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

During 2013, we recorded a loss for a premium deficiency with respect to our closed block of long-term care insurance policies. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2010 loss recognition date, particularly as they related to emerging experience due to an increase in life expectancies and utilization of home health care services. Based on this deterioration, and combined with lower interest rates, 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 2013 we recorded $243 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $350 million partially offset by a related reinsurance recoverable of $107 million included in other long-term assets.

During 2012, we recorded a change in estimate associated with future policy benefits payable for our closed-block of long-term care insurance policies resulting in additional benefits expense of $29 million and a corresponding increase in future policy benefits payable. This change in estimate was based on current claim experience demonstrating an increase in the length of the time policyholders already in payment status remained in such status. Future policy benefits payable was increased to cover future payments to policyholders currently in payment status.

For our closed block of long-term care policies, actuarial assumptions used to estimate reserves are inherently uncertain due to the potential changes in trends in mortality, morbidity, persistency (the percentage of policies remaining in-force) and interest rates. As a result, our long term care reserves may be subject to material increases if these trends develop adversely to our expectations. The estimated increase in reserves and additional benefit expense from hypothetically modeling adverse variations in our actuarial assumptions, in the aggregate, could be up to $300 million, net of reinsurance. Although such hypothetical revisions are not currently appropriate, we believe they could occur based on past variances in experience and our expectation of the ranges of future experience that could reasonably occur. Generally accepted accounting principles do not allow us to unlock our assumptions for favorable items. This hypothetical modeling does not contemplate a divestiture situation. We are evaluating alternatives related to our closed block of long term care policies. While no decision has been made with respect to any course of action, if we were to divest this business, it is reasonably likely that we would have to recognize a material loss and that loss could exceed the amount provided above.

In addition, future policy benefits payable includes amounts of $210 million at December 31, 2014, $215 million at December 31, 2013, and $220 million at December 31, 2012 which are subject to 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and

Supplementary Data, and as such are offset by a related reinsurance recoverable included in other long-term assets.

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Revenue Recognition

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

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

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

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

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all Medicare Advantage 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 Medicare Advantage plans. Rates paid to Medicare Advantage 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. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model is more fully described in Item 1. – Business under the section titled "Individual Medicare."

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Investment Securities

Investment securities totaled $9.5 billion, or 41% of total assets at December 31, 2014, and $9.8 billion, or 47% of total assets at December 31, 2013. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2014 and 2013. The fair value of debt securities were as follows at December 31, 2014 and 2013:

	December 31, 2014	Percentage of Total	December 31, 2013	Percentage of Total
	(dollars in millions)			
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$374	3.9 %	$584	6.0 %
Mortgage-backed securities	1,498	15.7 %	1,820	18.6 %
Tax-exempt municipal securities	3,068	32.1 %	2,971	30.3 %
Mortgage-backed securities:				
Residential	17	0.2 %	22	0.2 %
Commercial	843	8.8 %	673	6.9 %
Asset-backed securities	29	0.3 %	63	0.6 %
Corporate debt securities	3,718	39.0 %	3,667	37.4 %
Total debt securities	$9,547	100.0 %	$9,800	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, 2014. 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 $199 million at December 31, 2014 and $222 million at December 31, 2013. 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 $1.0 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 $1.8 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 11%. In addition, certain monoline insurers guarantee the timely repayment of bond principal and interest when a bond issuer defaults and generally provide credit enhancement for bond issues related to our tax-exempt municipal securities. We have no direct exposure to these monoline insurers. We owned $484 million and $548 million at December 31, 2014 and 2013, respectively, of tax-exempt securities guaranteed by monoline insurers. The equivalent weighted average S&P credit rating of these tax-exempt securities without the guarantee from the monoline insurer was AA.

Our direct exposure to subprime mortgage lending is limited to investment in residential mortgage-backed securities and asset-backed securities backed by home equity loans. The fair value of securities backed by Alt-A and subprime loans was $1 million at December 31, 2014 and 2013. There are no collateralized debt obligations or structured investment vehicles in our investment portfolio. The percentage of corporate securities associated with the financial

services industry was 21% at December 31, 2014 and 23% at December 31, 2013.

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, 2014:

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	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, 2014						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$79	$—	$80	$(1)	$159	$(1)
Mortgage-backed securities	22	—	320	(5)	342	(5)
Tax-exempt municipal securities	131	(1)	118	(2)	249	(3)
Mortgage-backed securities:						
Residential	1	—	4	—	5	—
Commercial	31	(1)	267	(18)	298	(19)
Asset-backed securities	13	—	—	—	13	—
Corporate debt securities	219	(6)	128	(7)	347	(13)
Total debt securities	$496	$(8)	$917	$(33)	$1,413	$(41)

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

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

other-than-temporary impairments may be recorded in future periods.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2014 primarily were composed of senior tranches having high

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credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2014.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2014 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2014, 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, 2014. There were no material other-than-temporary impairments in 2014, 2013, or 2012.

Goodwill and Long-lived Assets

At December 31, 2014, goodwill and other long-lived assets represented 24% of total assets and 59% of total stockholders' equity, compared to 27% and 61%, respectively, at December 31, 2013.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition. The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2014 segment change discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law, 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.

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.

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ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. Prior to 2009, under interest rate swap agreements, we exchanged the fixed interest rate under all of our senior notes for a variable interest rate based on LIBOR using interest rate swap agreements. We terminated all of our interest rate swap agreements in 2008. We may re-enter into interest rate swap agreements in the future depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $1.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2014 or December 31, 2013.

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, 2014. Our net unrealized position increased $225 million from a net unrealized gain position of $250 million at December 31, 2013 to a net unrealized gain position of $475 million at December 31, 2014. At December 31, 2014, we had gross unrealized losses of $41 million on our investment portfolio primarily due to an increase in market interest rates in the current markets than when the securities were purchased, and as such, there were no material other-than-temporary impairments during 2014. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio’s cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 4.1 years as of December 31, 2014 and 4.3 years as of December 31, 2013. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $466 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, 2014 and 2013. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have exceeded 300 basis points once, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points three times, and have changed by less than 100 basis points six times.

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	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, 2014						
Investment income (a)	$(20)	$(15)	$(9)	$42	$85	$128
Interest expense (b)	—	—	—	—	—	—
Pretax	$(20)	$(15)	$(9)	$42	$85	$128
As of December 31, 2013						
Investment income (a)	$(24)	$(16)	$(8)	$26	$52	$79
Interest expense (b)	—	—	—	—	—	—
Pretax	$(24)	$(16)	$(8)	$26	$52	$79

(a) As of December 31, 2014 and 2013, 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, 2014 or December 31, 2013 or under our commercial paper program (commenced in October 2014) at December 31, 2014.

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.

CONSOLIDATED BALANCE SHEETS

	December 31, 2014	2013
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$1,935	$1,138
Investment securities	7,598	8,090
Receivables, less allowance for doubtful accounts of $137 in 2014 and $118 in 2013	1,168	950
Other current assets	4,011	2,122
Total current assets	14,712	12,300
Property and equipment, net	1,419	1,218
Long-term investment securities	1,949	1,710
Goodwill	3,711	3,733
Other long-term assets	1,675	1,774
Total assets	$23,466	$20,735
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$4,475	$3,893
Trade accounts payable and accrued expenses	2,185	1,821
Book overdraft	334	403
Unearned revenues	361	206
Total current liabilities	7,355	6,323
Long-term debt	3,825	2,600
Future policy benefits payable	2,349	2,207
Other long-term liabilities	291	289
Total liabilities	13,820	11,419
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; 197,951,551 shares issued at December 31, 2014 and 196,275,506 shares issued at December 31, 2013	33	33
Capital in excess of par value	2,330	2,267
Retained earnings	9,916	8,942
Accumulated other comprehensive income	223	158
Treasury stock, at cost, 48,347,541 shares at December 31, 2014 and 42,245,097 shares at December 31, 2013	(2,856)	(2,084)
Total stockholders' equity	9,646	9,316
Total liabilities and stockholders' equity	$23,466	$20,735

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

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Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2014	2013	2012
	(in millions, except per share results)		
Revenues:			
Premiums	$45,959	$38,829	$37,009
Services	2,164	2,109	1,726
Investment income	377	375	391
Total revenues	48,500	41,313	39,126
Operating expenses:			
Benefits	38,166	32,564	30,985
Operating costs	7,639	6,355	5,830
Depreciation and amortization	333	333	295
Total operating expenses	46,138	39,252	37,110
Income from operations	2,362	2,061	2,016
Interest expense	192	140	105
Income before income taxes	2,170	1,921	1,911
Provision for income taxes	1,023	690	689
Net income	$1,147	$1,231	$1,222
Basic earnings per common share	$7.44	$7.81	$7.56
Diluted earnings per common share	$7.36	$7.73	$7.47
Dividends declared per common share	$1.11	$1.07	$1.03

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

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Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2014	2013	2012
	(in millions)		
Net income	$1,147	$1,231	$1,222
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	122	(338)	164
Effect of income taxes	(44)	124	(60)
Total change in unrealized investment gains/losses, net of tax	78	(214)	104
Reclassification adjustment for net realized gains included in investment income	(20)	(22)	(33)
Effect of income taxes	7	8	12
Total reclassification adjustment, net of tax	(13)	(14)	(21)
Other comprehensive income (loss), net of tax	65	(228)	83
Comprehensive income	$1,212	$1,003	$1,305

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

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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, 2012	193,230	$32	$1,938	$6,825	$303	$(1,035)	$8,063
Net income				1,222			1,222
Other comprehensive income					83		83
Common stock repurchases						(518)	(518)
Dividends and dividend equivalents			—	(166)			(166)
Stock-based compensation			82				82
Restricted stock grants and restricted stock unit vesting	15	—					—
Restricted stock forfeitures	(1)	—	—				—
Stock option exercises	1,227	—	60				60
Stock option and restricted stock tax benefit			21				21
Balances, December 31, 2012	194,471	32	2,101	7,881	386	(1,553)	8,847
Net income				1,231			1,231
Other comprehensive loss					(228)		(228)
Common stock repurchases						(531)	(531)
Dividends and dividend equivalents			—	(170)			(170)
Stock-based compensation			92				92
Restricted stock unit vesting	563	—					—
Stock option exercises	1,242	1	66				67
Stock option and restricted			8				8

stock tax benefit							
Balances, December 31, 2013	196,276	33	2,267	8,942	158	(2,084)	9,316
Net income				1,147			1,147
Other comprehensive income					65		65
Common stock repurchases			(100)			(772)	(872)
Dividends and dividend equivalents			—	(173)			(173)
Stock-based compensation			98				98
Restricted stock unit vesting	966	—					—
Stock option exercises	710	—	52				52
Stock option and restricted stock tax benefit			13				13
Balances, December 31, 2014	197,952	$33	$2,330	$9,916	$223	$(2,856)	$9,646

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

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Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2014	2013	2012
	(in millions)		
Cash flows from operating activities			
Net income	$1,147	$1,231	$1,222
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	449	426	338
Stock-based compensation	98	92	82
Net realized capital gains	(20)	(22)	(33)
(Benefit) provision for deferred income taxes	(64)	42	(80)
Provision for doubtful accounts	32	37	26
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(264)	(251)	326
Other assets	(952)	(330)	(253)
Benefits payable	582	109	(41)
Other liabilities	413	313	300
Unearned revenues	155	(24)	(43)
Other	42	93	79
Net cash provided by operating activities	1,618	1,716	1,923
Cash flows from investing activities			
Acquisitions, net of cash acquired	(18)	(187)	(1,235)
Proceeds from sale of business	72	34	—
Purchases of property and equipment	(528)	(441)	(410)
Proceeds from sales of property and equipment	—	4	—
Purchases of investment securities	(2,883)	(3,261)	(3,221)
Maturities of investment securities	885	1,077	1,497
Proceeds from sales of investment securities	2,409	1,592	1,404
Net cash used in investing activities	(63)	(1,182)	(1,965)
Cash flows from financing activities			
Receipts (withdrawals) from contract deposits, net	(919)	(150)	(397)
Proceeds from issuance of senior notes, net	1,733	—	990
Repayment of long-term debt	(500)	—	(36)
Common stock repurchases	(872)	(531)	(518)
Dividends paid	(172)	(168)	(165)
Excess tax benefit from stock-based compensation	12	8	22
Change in book overdraft	(69)	79	18
Proceeds from stock option exercises and other, net	29	60	57
Net cash used in financing activities	(758)	(702)	(29)
Increase (decrease) in cash and cash equivalents	797	(168)	(71)
Cash and cash equivalents at beginning of year	1,138	1,306	1,377

Cash and cash equivalents at end of year	$1,935	$1,138	$1,306
Supplemental cash flow disclosures:			
Interest payments	$143	$146	$110
Income tax payments, net	$1,030	$734	$745
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$18	$196	$1,535
Less: Fair value of liabilities assumed	—	(9)	(300)
Cash paid for acquired businesses, net of cash acquired	$18	$187	$1,235

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

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Humana, Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
1. REPORTING ENTITY
Nature of Operations
Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. The company's strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 73% of our total premiums and services revenue from contracts with the federal government in 2014, 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 long-term management agreements with the affiliated Professional Associations, or P.A.s, that operate these medical practices. Based upon the provisions of these agreements, these affiliated P.A.s are variable interest entities and we are the primary beneficiary, and accordingly we consolidated the affiliated P.A.s. All significant intercompany balances and transactions have been eliminated.
The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, future policy benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.
Business Segment Reclassifications
On January 1, 2014, we reclassified certain of our businesses from our Healthcare Services segment to our Employer Group segment to correspond with internal management reporting changes. Our reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. See Note 17 for segment financial information.
Health Care Reform
The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges coupled with three premium stabilization programs, as described more fully below.

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The Health Care Reform Law imposes an annual premium-based fee on health insurers for each calendar year beginning on or after January 1, 2014 which is not deductible for tax purposes. We are required to estimate a liability for the health insurer fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurer fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurer fee in September of each year. In September 2014, we paid the federal government $562 million for the annual health insurance industry fee attributed to calendar year 2014, in accordance with the Health Care Reform Law.

The Health Care Reform Law also establishes risk spreading premium stabilization programs effective January 1, 2014. The risk spreading programs are applicable to certain of our commercial medical insurance products. In the aggregate, our commercial medical insurance products represented approximately 18% of our total premiums and services revenue for the year ended December 31, 2014. 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 are for years 2014 through 2016, with potential for additional reinsurance recoveries through 2018 to the extent funds are available. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the Health Care Reform Law to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the Health Care Reform Law.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans (except certain exempt and grandfathered plans as discussed above) operating both inside and outside of the health insurance exchanges established under the Health Care Reform Law. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state. Each health insurance issuer’s average risk score is compared to the state’s average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. We generally rely on providers, including certain network providers who are our employees, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for our risk scores under the program. Our estimate of amounts receivable and/or payable under the risk adjustment program is based on our estimate of both our own and the state average risk scores. Assumptions used in these estimates include but are not limited to geographic considerations including our historical experience in markets we have participated in over a long period of time, member demographics (including age and gender for our members and other health insurance issuers), our pricing model, sales data for each metal tier (different metal tiers yield different risk scores), the mix of previously underwritten membership as compared to new members in plans compliant with the Health Care Reform Law, published third party studies, and other publicly available data including regulatory plan filings. We expect to refine our estimates as new information becomes available, including additional data released by the Department of Health and Human Services, or HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS, however, there will be no payments associated with these audits for 2014 or 2015, the first two years of the

program.

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

making additional payments to us or require us to refund HHS a portion of the premiums we received. HHS guidance provides that risk corridor collections over the life of the three year program will first be applied to any shortfalls from previous benefit years before application to current year obligations.

We estimate and recognize adjustments to premiums revenue for the risk adjustment and risk corridor provisions by projecting our ultimate premium for the calendar year separately for individual and group plans by state and legal entity. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. We record receivables or payables at the individual or group level within each state and legal entity and classify the amounts as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

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

We are required to remit payment for our per member reinsurance contribution, exclusive of the portion payable to the U.S. Treasury, by January 15 of the year following the benefit year, or January 15, 2015 for the 2014 benefit year. The portion of the reinsurance contribution due to the U.S. Treasury must be paid by November 15 of the year following the benefit year, or November 15, 2015 for the 2014 benefit year. Risk adjustment calculations will be completed and HHS will notify us of recoveries due or payments owed to/from us under the risk adjustment and reinsurance programs by June 30 of the year following the benefit year. Following this notification, risk corridor calculations are then due by July 31 of the year following the benefit year. Payments due to HHS under the risk adjustment and risk corridor programs must be remitted within 30 days of notification for each program and will be collected prior to the distribution of recoveries by HHS under each program. Payment and recovery amounts will be settled with HHS annually in the second half of the year following the benefit year. Accordingly, for the 2014 benefit year, we expect to receive recoveries and/or pay amounts due under these programs in the second half of 2015.

In addition to the provisions discussed above, beginning in 2014, HHS pays us a portion of the health care costs for low-income individual members for which we assume no risk in accordance with the Health Care Reform Law. We account for these subsidies as a deposit in our consolidated balance sheets and as a financing activity in our consolidated statements of cash flows. We do not recognize premiums revenue or benefits expense for these subsidies. Receipt and payment activity is accumulated at the state and legal entity level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the state and legal entity balance at the end of the reporting period. We will be notified of final settlement amounts by June 30 of the year following the benefit year. Receipts from HHS associated with cost sharing subsidies for which we do not assume risk were approximately $281 million, exceeding payments of $255 million by $26 million for the year ended December 31, 2014. See Note 7 for detail regarding amounts recorded to the consolidated balance sheets related to the 3Rs.

Cash and Cash Equivalents

Cash and cash equivalents include cash, time deposits, money market funds, commercial paper, other money market instruments, and certain U.S. Government securities with an original maturity of three months or less. Carrying value

approximates fair value due to the short-term maturity of the investments.

Investment Securities

Investment securities, which consist entirely of debt securities, have been categorized as available for sale and, as a result, are stated at fair value. Investment securities available for current operations are classified as current assets.

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

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

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

Receivables and Revenue Recognition

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

Premiums Revenue

We bill and collect premium remittances from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from CMS for our Medicare products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are recognized when the amounts become determinable and the collectibility is reasonably assured. Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the individual, small group, and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Beginning in 2014, Medicare Advantage products were also subject to minimum benefit ratio requirements under the Health Care

Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic

conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

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

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

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2014, subsidy and discount payments of $6.7 billion exceeded reimbursements of $5.8 billion by $945 million. For 2013, subsidy and discount payments of $4.8 billion exceeded reimbursements of $4.6 billion by $154 million. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

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

Military Services

On April 1, 2012, we began delivering services under our current TRICARE South Region contract with the DoD. Under the terms of the current TRICARE South Region contract, the federal government retains all of the risk of the cost of health benefits and we do not record premiums revenue or benefits expense in our consolidated statements of

income related to these health care costs and related reimbursements. Instead, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement as discussed further under our description of services revenue that follows. Our previous TRICARE South Region contract that expired on March 31, 2012 provided a financial interest in the underlying health care cost; therefore, we reported revenues on a

gross basis. We shared the risk with the federal government for the cost of health benefits incurred under our previous contract, earning more revenue or incurring additional cost based on the variance of actual health care costs from an annually negotiated target health care cost. TRICARE revenues under the previous contract consisted generally of (1) an insurance premium for assuming underwriting risk for the cost of civilian health care services delivered to eligible beneficiaries; (2) health care services provided to beneficiaries which were in turn reimbursed by the federal government; and (3) administrative services fees related to claim processing, customer service, enrollment, and other services. We recognized the insurance premium as revenue ratably over the period coverage was provided. Health care services reimbursements were recognized as revenue in the period health services were provided. Administrative services fees were recognized as revenue in the period services were performed. We deferred the recognition of any contingent revenues for favorable variances until the end of the contract period when the amount was determinable and the collectibility was reasonably assured. We estimated and recognized contingent benefits expense for unfavorable variances currently in our results of operations.

Services Revenue

Patient services revenue

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

Administrative services fees

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

On April 1, 2012, we began delivering services under our current TRICARE South Region contract with the DoD. Under the current contract, we provide administrative services, including offering access to our provider networks and clinical programs, claim processing, customer service, enrollment, and other services, while the federal government retains all of the risk of the cost of health benefits. We account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. The current contract includes fixed administrative services fees and incentive fees and penalties. Administrative services fees are recognized as services are performed.

Our TRICARE members are served by both in-network and out-of-network providers in accordance with the current contract. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government’s claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2014, health care cost reimbursements and payments were each approximately $3.2 billion for the year. For 2013, health care cost reimbursements were $3.2 billion, exceeding payments of $3.2 billion by $5 million. For the first nine months of the current contract, April 1, 2012 to December 31, 2012, health care cost payments were $2.1 billion, exceeding

reimbursements of $2.0 billion by $56 million.

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.

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 cancelled upon 30 days notice by the employer group.

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

Beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model and accordingly policy acquisition costs are expensed as incurred because premiums received in the current year are intended to pay anticipated benefits in that year.

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 7 years for computer software, and 20 to 40 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

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

Goodwill and Other Intangible Assets

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

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Impairment tests are performed, at a minimum, in the

fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an

evaluation of future discounted cash flows to determine fair value of our reporting units. Impairment tests completed for 2014, 2013, and 2012 did not result in an impairment loss.

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

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided 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.

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 liability 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 do not anticipate recording a material premium deficiency liability, 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 including long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if

adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs. We adjust future policy benefits payable for the additional liability that would have been recorded if investment securities backing the

liability had been sold at their stated aggregate fair value and the proceeds reinvested at current yields. We include the impact of this adjustment, if any, net of applicable deferred taxes, with the change in unrealized investment gain (loss) in accumulated other comprehensive income in stockholders' equity. As discussed above, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model under which policy reserves are not established because premiums received in the current year are intended to pay anticipated benefits in that year.

Book Overdraft

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

Income Taxes

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

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

Derivative Financial Instruments

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, a privately held Medical Services Organization, or MSO, headquartered in Miami, Florida that coordinates medical care for Medicare Advantage and Medicaid beneficiaries primarily in Florida and Texas. Our agreement with MCCI includes a put option that would allow the controlling interest holder to put their interest to us after a specified date as well as a call option that would allow us to purchase the controlling interest after a specified date. Accordingly, we recorded, at fair value, a liability and an asset associated with the put and call, respectively. Changes in the fair value of the liability and asset during the years ended December 31, 2014, 2013, and 2012 were not material to our results of operations, financial condition, or cash flows.

At times, we may use interest-rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as adjustments to interest expense in the consolidated statements of income. We were not party to any interest-rate swap agreements in 2014, 2013, or 2012.

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). However, for awards granted to retirement eligible employees, the compensation expense is recognized on a straight-line basis over the shorter of the requisite service period or the period from the date of grant to an employee's eligible retirement date. 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. In addition, we report certain tax effects of stock-based compensation as a

financing activity rather than an operating activity in the consolidated statement of cash flows. Additional detail regarding our stock-based compensation plans is included in Note 13.

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Earnings Per Common Share

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

Fair Value

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

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

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

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

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

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

could not be estimated based on observable market prices, and as such, unobservable inputs were used. For auction

rate securities, valuation methodologies include consideration of the quality of the sector and issuer, underlying collateral, underlying final maturity dates, and liquidity.

Recently Issued Accounting Pronouncements

In April 2014, the Financial Accounting Standards Board, or FASB, issued new guidance related to discontinued operations which changes the criteria for determining which disposals can be presented as discontinued operations and modifies related disclosure requirements. The new guidance is effective for us beginning with annual and interim periods in 2015 with early adoption permitted under certain circumstances. Based upon existing facts and circumstances, the adoption of the new guidance is not expected to have a material impact on our results of operations, financial condition, or cash flows.

In May 2014, the FASB issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not in the scope of this new guidance. The new guidance is effective for us beginning with annual and interim periods in 2017. We are currently evaluating the impact on our results of operations, financial condition, and cash flows.

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

3. ACQUISITIONS

On September 6, 2013, we acquired American Eldercare Inc., or American Eldercare, the largest provider of nursing home diversion services in the state of Florida, serving frail and elderly individuals in home and community-based settings. American Eldercare complements our core capabilities and strength in serving seniors and disabled individuals with a unique focus on individualized and integrated care, and has contracts to provide Medicaid long-term support services across the entire state of Florida. The enrollment effective dates for the various regions ranged from August 2013 to March 2014. The allocation of the purchase price resulted in goodwill of $76 million and other intangible assets of $75 million. The goodwill was assigned to the Retail segment. The other intangible assets, which primarily consist of customer contracts and technology, have a weighted average useful life of 9.3 years. Goodwill and other intangible assets are amortizable as deductible expenses for tax purposes.

On December 21, 2012, we acquired Metropolitan Health Networks, Inc., or Metropolitan, an MSO that coordinates medical care for Medicare Advantage beneficiaries and Medicaid recipients, primarily in Florida. We acquired all of the outstanding shares of Metropolitan and repaid all outstanding debt of Metropolitan for a transaction value of $851 million, plus transaction expenses. The total consideration of $851 million exceeded our estimated fair value of the net tangible assets acquired by approximately $827 million, of which we allocated $263 million to other intangible assets and $564 million to goodwill. A majority of the goodwill was assigned to the Healthcare Services segment and a portion to our Retail segment. Goodwill and other intangible assets are not amortizable as deductible expenses for tax purposes. The other intangible assets, which primarily consist of customer contracts and trade names, have a weighted average useful life of 8.4 years.

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI, a privately held MSO headquartered in Miami, Florida that coordinates medical care for Medicare Advantage and Medicaid beneficiaries primarily in Florida and Texas.

The Metropolitan and MCCI transactions provide us with components of a successful integrated care delivery model that has demonstrated scalability to new markets. A substantial portion of the revenues for both Metropolitan and MCCI are derived from services provided to Humana Medicare Advantage members under capitation contracts with our health plans. In addition, Metropolitan and MCCI provide services to Medicare Advantage and Medicaid members under capitation contracts with third party health plans. Under these capitation agreements with Humana and third party health plans, Metropolitan and MCCI assume financial risk associated with these Medicare Advantage and

Medicaid members.

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On July 6, 2012, we acquired Humana At Home, Inc. (formerly known as SeniorBridge Family Companies, Inc.), or Humana At Home, a chronic-care provider of in-home care for seniors, expanding our existing clinical and home health capabilities and strengthening our offerings for members with complex chronic-care needs. The allocation of the purchase price resulted in goodwill of $99 million and other intangible assets of $14 million. The goodwill was assigned to the Healthcare Services segment. Goodwill and other intangible assets are not amortizable as deductible expenses for tax purposes. The other intangible assets, which primarily consist of customer contracts, trade name, and technology, have a weighted average useful life of 5.2 years.

Effective March 31, 2012, we acquired Arcadian Management Services, Inc., or Arcadian, a Medicare Advantage health maintenance organization (HMO) serving members in 15 U.S. states, increasing Medicare membership and expanding our Medicare footprint and future growth opportunities in these areas. The allocation of the purchase price resulted in goodwill of $44 million and other intangible assets of $38 million. The goodwill was assigned to the Retail segment. Goodwill and other intangible assets are not amortizable as deductible expenses for tax purposes. The other intangible assets, which primarily consist of customer contracts and provider contracts, have a weighted average useful life of 9.7 years.

The results of operations and financial condition of American Eldercare, Metropolitan, Humana At Home, and Arcadian have been included in our consolidated statements of income and consolidated balance sheets from the acquisition dates. In addition, during 2014, 2013 and 2012, we acquired other health and wellness and technology related businesses which, individually or in the aggregate, have not had, or are not expected to have, a material impact on our results of operations, financial condition, or cash flows. Acquisition-related costs recognized in each of 2014, 2013, and 2012 were not material to our results of operations. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the current year were not material for disclosure purposes.

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4. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2014 and 2013, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
	(in millions)			
December 31, 2014				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$365	$10	$(1)	$374
Mortgage-backed securities	1,453	50	(5)	1,498
Tax-exempt municipal securities	2,931	140	(3)	3,068
Mortgage-backed securities:				
Residential	17	—	—	17
Commercial	846	16	(19)	843
Asset-backed securities	28	1	—	29
Corporate debt securities	3,432	299	(13)	3,718
Total debt securities	$9,072	$516	$(41)	$9,547
December 31, 2013				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$584	$6	$(6)	$584
Mortgage-backed securities	1,834	34	(48)	1,820
Tax-exempt municipal securities	2,911	93	(33)	2,971
Mortgage-backed securities:				
Residential	22	—	—	22
Commercial	662	20	(9)	673
Asset-backed securities	63	1	(1)	63
Corporate debt securities	3,474	223	(30)	3,667
Total debt securities	$9,550	$377	$(127)	$9,800

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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, 2014 and 2013, 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, 2014						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$79	$—	$80	$(1)	$159	$(1)
Mortgage-backed securities	22	—	320	(5)	342	(5)
Tax-exempt municipal securities	131	(1)	118	(2)	249	(3)
Mortgage-backed securities:						
Residential	1	—	4	—	5	—
Commercial	31	(1)	267	(18)	298	(19)
Asset-backed securities	13	—	—	—	13	—
Corporate debt securities	219	(6)	128	(7)	347	(13)
Total debt securities	$496	$(8)	$917	$(33)	$1,413	$(41)
December 31, 2013						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$231	$(6)	$5	$—	$236	$(6)
Mortgage-backed securities	1,076	(47)	21	(1)	1,097	(48)
Tax-exempt municipal securities	693	(28)	57	(5)	750	(33)
Mortgage-backed securities:						
Residential	6	—	1	—	7	—
Commercial	270	(8)	40	(1)	310	(9)
Asset-backed securities	35	(1)	—	—	35	(1)
Corporate debt securities	594	(28)	17	(2)	611	(30)
Total debt securities	$2,905	$(118)	$141	$(9)	$3,046	$(127)

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2014. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. At December 31, 2014, 7% of our tax-exempt municipal securities were pre-refunded, generally with U.S. government and agency securities. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for 36% of the tax-exempt municipals that were not pre-refunded in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for the remaining 64% of these municipals. Our general obligation bonds are diversified across the United States with no individual state exceeding 11%. In addition, 16% of our tax-exempt securities were insured by bond insurers and had an equivalent weighted

average S&P credit rating of AA exclusive of the bond insurers' guarantee. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

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The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2014 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2014.

The percentage of corporate securities associated with the financial services industry was 21% at December 31, 2014 and 23% at December 31, 2013.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2014 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2014, 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, 2014.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2014, 2013, and 2012:

	2014	2013	2012
	(in millions)		
Gross realized gains	$29	$33	$38
Gross realized losses	(9)	(11)	(5)
Net realized capital gains	$20	$22	$33

There were no material other-than-temporary impairments in 2014, 2013, or 2012.

The contractual maturities of debt securities available for sale at December 31, 2014, 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	$530	$534
Due after one year through five years	2,060	2,164
Due after five years through ten years	2,036	2,145
Due after ten years	2,102	2,317
Mortgage and asset-backed securities	2,344	2,387
Total debt securities	$9,072	$9,547

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5. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2014 and 2013, 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, 2014				
Cash equivalents	$1,712	$1,712	$—	$—
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	374	—	374	—
Mortgage-backed securities	1,498	—	1,498	—
Tax-exempt municipal securities	3,068	—	3,060	8
Mortgage-backed securities:				
Residential	17	—	17	—
Commercial	843	—	843	—
Asset-backed securities	29	—	28	1
Corporate debt securities	3,718	—	3,695	23
Total debt securities	9,547	—	9,515	32
Total invested assets	$11,259	$1,712	$9,515	$32
December 31, 2013				
Cash equivalents	$876	$876	$—	$—
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	584	—	584	—
Mortgage-backed securities	1,820	—	1,820	—
Tax-exempt municipal securities	2,971	—	2,958	13
Mortgage-backed securities:				
Residential	22	—	22	—
Commercial	673	—	673	—
Asset-backed securities	63	—	62	1
Corporate debt securities	3,667	—	3,644	23
Total debt securities	9,800	—	9,763	37
Total invested assets	$10,676	$876	$9,763	$37

There were no material transfers between Level 1 and Level 2 during 2014 or 2013.

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Our Level 3 assets had a fair value of $32 million at December 31, 2014, or 0.3% of our total invested assets. During the years ended December 31, 2014, 2013, and 2012, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the years ended December 31,								
	2014			2013			2012		
	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total
	(in millions)								
Beginning balance at January 1	$24	$13	$37	$25	$13	$38	$25	$16	$41
Total gains or losses:									
Realized in earnings	—	—	—	—	—	—	—	—	—
Unrealized in other comprehensive income	—	—	—	—	—	—	—	—	—
Purchases	—	—	—	—	—	—	—	—	—
Sales	—	(5)	(5)	—	—	—	—	(3)	(3)
Settlements	—	—	—	(1)	—	(1)	—	—	—
Balance at December 31	$24	$8	$32	$24	$13	$37	$25	$13	$38

Financial Liabilities

Our long-term debt, recorded at carrying value in our consolidated balance sheets, was $3,825 million at December 31, 2014 and $2,600 million at December 31, 2013. The fair value of our long-term debt was $4,102 million at December 31, 2014 and $2,751 million at December 31, 2013. The fair value of our long-term debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we completed our acquisitions of American Eldercare, Metropolitan, SeniorBridge, Arcadian, and other companies during 2014, 2013, and 2012. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the related tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected cash flows and discount rates in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no assets or liabilities measured at fair value on a nonrecurring basis during 2014, 2013, or 2012.

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6. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2014 and 2013:

	2014 Risk Corridor Settlement	2014 CMS Subsidies/ Discounts	2013 Risk Corridor Settlement	2013 CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$105	$1,690	$45	$743
Trade accounts payable and accrued expenses	(36)	(32)	(71)	(30)
Net current asset (liability)	$69	$1,658	$(26)	$713

7. COMMERCIAL 3Rs

The accompanying consolidated balance sheets include the following amounts associated with the 3Rs at December 31, 2014. No such amounts were recorded in our consolidated balance sheet at December 31, 2013 as the programs were not effective until January 1, 2014.

	2014 Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement
	(in millions)		
Premiums receivable	$131	$—	$—
Other current assets	—	586	55
Trade accounts payable and accrued expenses	(89)	—	(4)
Net current asset	$42	$586	$51

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2014 and 2013:

	2014	2013
	(in millions)	
Land	$20	$20
Buildings and leasehold improvements	763	693
Equipment	709	639
Computer software	1,714	1,396
	3,206	2,748
Accumulated depreciation	(1,787)	(1,530)
Property and equipment, net	$1,419	$1,218

Depreciation expense was $328 million in 2014, $309 million in 2013, and $263 million in 2012, including amortization expense for capitalized internally developed and purchased software of $191 million in 2014, $172 million in 2013, and $151 million in 2012.

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9. GOODWILL AND OTHER INTANGIBLE ASSETS

The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2014 segment change discussed in Note 2. Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2014 and 2013 were as follows:

	Retail	Employer Group	Healthcare Services	Other Businesses	Total
	(in millions)				
Balance at December 31, 2012	$931	$363	$2,254	$92	$3,640
Acquisitions	76	—	40	—	116
Dispositions	—	—	(17)	—	(17)
Subsequent payments/adjustments	—	—	(6)	—	(6)
Balance at December 31, 2013	1,007	363	2,271	92	3,733
Acquisitions	—	—	19	—	19
Dispositions	—	—	(40)	—	(40)
Subsequent payments/adjustments	—	—	(1)	—	(1)
Balance at December 31, 2014	$1,007	$363	$2,249	$92	$3,711

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, 2014 and 2013:

	Weighted Average Life	2014			2013		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
		(in millions)					
Other intangible assets:							
Customer contracts/relationships	9.8 years	$764	$368	$396	$792	$310	$482
Trade names and technology	13.2 years	198	66	132	200	40	160
Provider contracts	15.0 years	51	21	30	51	23	28
Noncompetes and other	6.5 years	51	37	14	52	29	23
Total other intangible assets	10.5 years	$1,064	$492	$572	$1,095	$402	$693

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Amortization expense for other intangible assets was approximately $121 million in 2014, $117 million in 2013, and $75 million in 2012. 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,:	
2015	$101
2016	94
2017	85
2018	78
2019	66

10. BENEFITS PAYABLE

Activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
	(in millions)		
Balances at January 1	$3,893	$3,775	$3,415
Acquisitions	—	5	66
Incurred related to:			
Current year	38,641	32,711	30,198
Prior years	(518)	(474)	(257)
Total incurred	38,123	32,237	29,941
Paid related to:			
Current year	(34,357)	(29,103)	(26,738)
Prior years	(3,262)	(3,021)	(2,909)
Total paid	(37,619)	(32,124)	(29,647)
Reinsurance recoverable	78	—	—
Balances at December 31	$4,475	$3,893	$3,775

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).

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 $518 million in 2014, $474 million in 2013, and $257 million in 2012. The favorable medical claims reserve development for 2014, 2013, and 2012 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. The improvements during 2014 and 2013 resulted from increased membership and favorable medical claims reserve development due to better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

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Benefits expense associated with military services and provisions associated with future policy benefits excluded from the previous table was as follows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
	(in millions)		
Military services	$11	$(27)	$908
Future policy benefits	32	354	136
Total	$43	$327	$1,044

Military services benefit expense for 2014 reflects expenses associated with our contracts with the Veterans Administration. Military services benefit expense for 2013 reflects the beneficial effect of a favorable settlement of contract claims with the DoD partially offset by expenses associated with our contracts with the Veterans Administration. Due to the transition to the current TRICARE South Region contract on April 1, 2012, which is accounted for as an administrative services only contract as more fully described in Note 2 there was no military services benefits payable at December 31, 2014 or 2013. This transition is also the primary reason for the decline in military services benefits expense from 2012 to 2013.

The higher benefits expense associated with future policy benefits payable during 2013 relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG America Corporation, or KMG, acquisition more fully described in Note 18.

11. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
	(in millions)		
Current provision:			
Federal	$1,006	$595	$708
States and Puerto Rico	81	53	61
Total current provision	1,087	648	769
Deferred (benefit) provision	(64)	42	(80)
Provision for income taxes	$1,023	$690	$689

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2014, 2013 and 2012 due to the following:

	2014	2013	2012
	(in millions)		
Income tax provision at federal statutory rate	$759	$672	$669
States, net of federal benefit, and Puerto Rico	48	32	27
Tax exempt investment income	(27)	(26)	(26)
Health insurer fee	204	—	—
Nondeductible executive compensation	22	6	14
Other, net	17	6	5
Provision for income taxes	$1,023	$690	$689

The provision for income taxes for 2014, 2013, and 2012 reflects a $22 million, $6 million, and $14 million, respectively, estimated impact from limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law.

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As of December 31, 2014, we do not have material uncertain tax positions reflected in our consolidated balance sheet. Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled. Principal components of our net deferred tax balances at December 31, 2014 and 2013 were as follows:

	Assets (Liabilities)	
	2014	2013
	(in millions)	
Future policy benefits payable	$320	$303
Compensation and other accrued expenses	176	185
Benefits payable	138	111
Net operating loss carryforward	52	51
Deferred acquisition costs	57	46
Unearned premiums	21	10
Other	18	10
Total deferred income tax assets	782	716
Valuation allowance	(48)	(28)
Total deferred income tax assets, net of valuation allowance	734	688
Depreciable property and intangible assets	(410)	(453)
Investment securities	(168)	(78)
Prepaid expenses	(55)	(83)
Total deferred income tax liabilities	(633)	(614)
Total net deferred income tax assets (liabilities)	$101	$74
Amounts recognized in the consolidated balance sheets:		
Other current assets	$87	$60
Other long-term assets	14	14
Trade accounts payable and accrued expenses	—	—
Total net deferred income tax assets (liabilities)	$101	$74

At December 31, 2014, we had approximately $141 million of net operating losses to carry forward related to prior acquisitions and our Puerto Rico subsidiaries. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2015 through 2033. Due to limitations and uncertainty regarding our ability to use some of the carryforwards, a valuation allowance was established on $108 million of these net operating loss carryforwards and $20 million of other items related to Puerto Rico. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover all deferred tax assets.

We provide for income taxes on the undistributed earnings of our Puerto Rico operations using that jurisdiction’s tax rate, which has been lower historically than the U.S. statutory tax rate. Permanent investment of these earnings has resulted in cumulative unrecognized deferred tax liabilities of approximately $31 million as of December 31, 2014.

We file income tax returns in the United States and certain foreign jurisdictions. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2012 and prior years. Our 2013 tax return is in the post-filing review period under the Compliance Assurance Process (CAP). Our 2014 tax return is under advance review by the IRS under CAP. With few exceptions, which are immaterial in the aggregate, we no longer are

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subject to state, local and foreign tax examinations for years before 2011. As of December 31, 2014, we are not aware of any material adjustments that may be proposed.

12. DEBT

The carrying value of long-term debt outstanding was as follows at December 31, 2014 and 2013:

	2014	2013
	(in millions)	
Long-term debt:		
Senior notes:		
$500 million, 6.45% due June 1, 2016	$—	$517
$500 million, 7.20% due June 15, 2018	504	505
$300 million, 6.30% due August 1, 2018	312	314
$400 million, 2.625% due October 1, 2019	400	—
$600 million, 3.15% due December 1, 2022	598	598
$600 million, 3.85% due October 1, 2024	599	—
$250 million, 8.15% due June 15, 2038	266	266
$400 million, 4.625% due December 1, 2042	400	400
$750 million, 4.95% due October 1, 2044	746	—
Total long-term debt	$3,825	$2,600

Senior Notes

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

In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $560 million. We recognized a loss on extinguishment of debt, included in interest expense, of approximately $37 million for the redemption of these 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 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes (other than the 6.30% senior notes) contain a change of control provision that may require us to purchase the notes under certain circumstances.

Prior to 2009, we were parties to interest-rate swap agreements that exchanged the fixed interest rate under our senior notes for a variable interest rate based on LIBOR. As a result, the carrying value of the senior notes was adjusted to reflect changes in value caused by an increase or decrease in interest rates. During 2008, we terminated all of our swap agreements. The cumulative adjustment to the carrying value of our senior notes was $103 million as of the termination date which is being amortized as a reduction to interest expense over the remaining term of the senior notes. In October 2014, the redemption of our 6.45% senior notes reduced the unamortized carrying value adjustment by $12 million. The unamortized carrying value adjustment was $32 million as of December 31, 2014 and $54 million as of December 31, 2013.

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Credit Agreement

Our 5-year $1.0 billion unsecured revolving credit agreement expires July 2018. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110 basis points, varies depending on our credit ratings ranging from 90 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 10 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $7.8 billion at December 31, 2014 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $9.6 billion and actual leverage ratio of 1.4:1, as measured in accordance with the credit agreement as of December 31, 2014. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2014, we had no borrowings outstanding under the credit agreement. We have outstanding letters of credit of $4 million issued under the credit agreement at December 31, 2014. No amounts have been drawn on these letters of credit. Accordingly, as of December 31, 2014, we had $996 million of remaining borrowing capacity under the credit agreement, none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

In October 2014, we entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time, with the aggregate face or principal amounts outstanding under the program at any time not to exceed $1 billion. The net proceeds of issuances have been and are expected to be used for general corporate purposes, including to repurchase shares of our common stock. The maximum principal amount of commercial paper borrowings outstanding at any one time during the year ended December 31, 2014 was $175 million. There were no outstanding borrowings at December 31, 2014.

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 $176 million in 2014, $155 million in 2013, and $138 million in 2012, all of which was funded currently to the extent it was deductible for federal income tax purposes. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $143.63 on December 31, 2014, approximately 13% of the retirement and savings plan's assets were invested in our common stock, or approximately 2.8 million shares, representing 2% of the shares outstanding as of December 31, 2014. At December 31, 2014, approximately 4.1 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

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Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock, including both restricted stock units and restricted stock awards, have been granted to executive officers, directors and key employees. The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. The stock awards of retirement-eligible participants will continue to vest upon retirement from the Company. 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, 2014, 2013, and 2012:

	2014	2013	2012
	(in millions)		
Stock-based compensation expense by type:			
Restricted stock	$91	$84	$66
Stock options	7	8	16
Total stock-based compensation expense	98	92	82
Tax benefit recognized	(22)	(22)	(21)
Stock-based compensation expense, net of tax	$76	$70	$61

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes. 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. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $30 million in 2014, $20 million in 2013, and $43 million in 2012. There was no capitalized stock-based compensation expense during these years.

At December 31, 2014, there were 19.3 million shares reserved for stock award plans. These reserved shares included giving effect to, under the 2011 Plan, 10.6 million shares of common stock available for future grants assuming all stock options were granted or 4.6 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 three years from the date of grant. Certain 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 $103.57 in 2014, $73.50 in 2013, and $85.29 in 2012. Activity for our restricted stock was as follows for the year ended December 31, 2014:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2013	3,642	$71.84
Granted	1,264	103.57
Vested	(972)	62.68
Forfeited	(299)	75.38
Nonvested restricted stock at December 31, 2014	3,635	$85.52

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The fair value of shares vested was $99 million during 2014, $52 million during 2013, and $75 million during 2012. Total compensation expense not yet recognized related to nonvested restricted stock was $92 million at December 31, 2014. 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 to 10 years after grant.

The weighted-average fair value of each option granted during 2014, 2013, and 2012 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:

	2014	2013	2012
Weighted-average fair value at grant date	$22.45	$21.80	$30.15
Expected option life (years)	4.3 years	4.4 years	4.4 years
Expected volatility	27.6 %	38.8 %	46.3 %
Risk-free interest rate at grant date	1.3 %	0.8 %	0.8 %
Dividend yield	1.1 %	1.5 %	1.2 %

When valuing employee stock options, we stratify the employee population into three homogenous 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, 2014:

	Shares Under Option (shares in thousands)	Weighted-Average Exercise Price
Options outstanding at December 31, 2013	1,272	$72.81
Granted	244	102.91
Exercised	(715)	72.27
Forfeited	(33)	82.78
Options outstanding at December 31, 2014	768	$82.45
Options exercisable at December 31, 2014	179	$67.57

As of December 31, 2014, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $49 million, and a weighted-average remaining contractual term of 4.4 years. As of December 31, 2014, exercisable stock options had an aggregate intrinsic value of $14 million, and a weighted-average remaining contractual term of 3.1 years. The total intrinsic value of stock options exercised during 2014 was $32 million, compared

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with $39 million during 2013 and $45 million during 2012. Cash received from stock option exercises totaled $52 million in 2014, $67 million in 2013, and $60 million in 2012.

Total compensation expense not yet recognized related to nonvested options was $6 million at December 31, 2014. We expect to recognize this compensation expense over a weighted-average period of approximately 1.6 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, 2014, 2013 and 2012:

	2014	2013	2012
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$1,147	$1,231	$1,222
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	154,187	157,503	161,484
Dilutive effect of:			
Employee stock options	230	322	576
Restricted stock	1,457	1,326	1,397
Shares used to compute diluted earnings per common share	155,874	159,151	163,457
Basic earnings per common share	$7.44	$7.81	$7.56
Diluted earnings per common share	$7.36	$7.73	$7.47
Number of antidilutive stock options and restricted stock awards excluded from computation	320	704	754

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15. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2012, 2013, and 2014 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount (in millions)
2012	$1.02	$165
2013	$1.06	$167
2014	$1.10	$170

In October 2014, the Board declared a cash dividend of $0.28 per share that was paid on January 30, 2015 to stockholders of record on December 31, 2014, for an aggregate amount of $42 million. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

Stock Repurchases

In September 2014, the Board of Directors replaced a previous share repurchase authorization of up to $1 billion (of which $816 million remained unused) with the current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Under the new share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. During 2014, we repurchased 1.60 million shares in open market transactions for $195 million at an average price of $121.68 under previous share repurchase authorizations and we repurchased 4.10 million shares in open market transactions for $535 million at an average price of $130.42 under the current authorization, including $400 million of shares repurchased under an accelerated stock repurchase, or ASR, agreement described further below. During 2013, we repurchased 5.77 million shares in open market transactions for $502 million at an average price of $86.97 under previous share repurchase authorizations. During 2012, we repurchased 6.25 million shares in open market transactions for $460 million at an average price of $73.66 under previous share repurchase authorizations. As of February 18, 2015, the remaining authorized amount under the current authorization totaled $1.37 billion, which includes $100 million of stock held back as part of the accelerated share repurchase agreement as more fully described below.

On November 7, 2014, we announced that we had entered into an accelerated share repurchase agreement, or ASR Agreement, with Goldman, Sachs & Co., or Goldman Sachs, to repurchase $500 million of our common stock as part of the $2 billion share repurchase program authorized in September 2014. Under the ASR Agreement, on November 10, 2014, we made a payment of $500 million to Goldman Sachs from available cash on hand and received an initial delivery of 3.06 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $400 million increase in treasury stock, which reflects the value of the initial 3.06 million shares received upon initial settlement, and a $100 million decrease in capital in excess of par value, which reflects the value of stock held back by Goldman Sachs pending final settlement of the ASR Agreement. The final number of shares that we may receive, or be required to remit, under the ASR Agreement will be determined based on the daily volume-weighted average share price of our common stock over the term of the ASR Agreement, less a discount and subject to adjustments pursuant to the terms and conditions of the ASR Agreement. Final settlement under the ASR Agreement will occur by the end of the first quarter of 2015. The ASR 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 of the ASR Agreement may be accelerated or extended or the ASR agreement may be terminated early by Goldman Sachs or us, 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

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common stock from Goldman Sachs 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. The obligations of Goldman Sachs under the ASR agreement are guaranteed by The Goldman Sachs Group, Inc.

In connection with employee stock plans, we acquired 0.4 million common shares for $42 million in 2014, 0.3 million common shares for $29 million in 2013, and 0.7 million common shares for $58 million in 2012.

Regulatory Requirements

Certain of our insurance 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 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.

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 $6.0 billion and $5.5 billion as of December 31, 2014 and 2013, respectively, which exceeded aggregate minimum regulatory requirements of $4.1 billion and $3.5 billion, respectively. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2015 is approximately $800 million in the aggregate. This compares to dividends that were paid to our parent company in 2014 of approximately $927 million.

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 2027. 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, 2014, 2013 and 2012:

	2014	2013	2012
	(in millions)		
Rent expense	$226	$227	$218
Sublease rental income	(14)	(11)	(11)
Net rent expense	$212	$216	$207

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Future annual minimum payments due subsequent to December 31, 2014 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments (in millions)	Sublease Rental Receipts	Net Lease Commitments
For the years ending December 31,:			
2015	$232	$(17)	$215
2016	198	(16)	182
2017	163	(15)	148
2018	110	(13)	97
2019	78	(9)	69
Thereafter	364	(9)	355
Total	$1,145	$(79)	$1,066

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 $94 million in 2015, $45 million in 2016, $20 million in 2017, $16 million in 2018, and none thereafter. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2014, we were not involved in any SPE transactions.

Guarantees and Indemnifications

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

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

Government Contracts

Our Medicare products, which accounted for approximately 72% of our total premiums and services revenue for the year ended December 31, 2014, 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

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in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2015, and all of our product offerings filed with CMS for 2015 have been approved.

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

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

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

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to the current round of RADV contract level audits being conducted on 2011 premium payments. Selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year. We have been notified that certain of our Medicare Advantage contracts have been selected for audit for contract year 2011.

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 benchmark audit data in Medicare FFS which has not yet been released. We based our accrual of estimated audit settlements for contract years 2011 (the first year that application of extrapolated audit results is applicable) through 2014 on the results of these internal contract level

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

In addition, CMS' comments in formalized guidance regarding “overpayments” to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS’ final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015,

appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2014, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2014, primarily consisted of the TRICARE South Region contract. The current five-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On January 27, 2015, we received notice from the Defense Health Agency, or DHA, of its intent to exercise its option to extend the TRICARE South Region contract through March 31, 2016.

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

Our state-based Medicaid business accounted for approximately 2% of our total premiums and services revenue for the year ended December 31, 2014. In addition to our state-based Medicaid contracts in Florida and Kentucky, we have contracts in Illinois and Virginia for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program. We began serving members in Illinois in the first quarter of 2014 and in Virginia in the second quarter of 2014. In addition, we began serving members in Long-Term Care Support Services (LTSS) regions in Florida at various effective dates ranging from the second half of 2013 through the first quarter of 2014.

On June 26, 2013, the Puerto Rico Health Insurance Administration notified us of its election not to renew our three-year Medicaid contracts for the East, Southeast, and Southwest regions which ended June 30, 2013. Contractual transition provisions required the continuation of insurance coverage for beneficiaries through September 30, 2013 and also required an additional period of time thereafter to process residual claims.

Legal Proceedings and Certain Regulatory Matters

Florida Matters

On December 16, 2010, an individual filed a qui tam suit captioned United States of America ex rel. Marc Osheroff v. Humana et al. in the Southern District of Florida, against us, several of our health plan subsidiaries, and certain other companies that operate medical centers in Miami-Dade County, Florida. After the U.S. government declined to intervene, the Court ordered the complaint unsealed, and the individual plaintiff amended his complaint and served the Company on December 8, 2011. The amended complaint alleged certain civil violations by our CAC Medical Centers in Florida, including offering various amenities such as transportation and meals, to Medicare and dual eligible individuals in our community center settings. The amended complaint also alleged civil violations by our Medicare Advantage health plans in Florida, arising from the alleged activities of our CAC Medical Centers and the codefendants in the complaint. The amended complaint sought damages and penalties on behalf of the United States under the Anti-Inducement and Anti-Kickback Statutes and the False Claims Act. On September 28, 2012, the Court dismissed, with prejudice, all causes of action that were asserted in the amended complaint. On November 19, 2013, the individual plaintiff appealed the dismissal of the amended complaint. On January 16, 2015, the Court of Appeals for the Eleventh Circuit affirmed the dismissal of the amended complaint.

On January 6, 2012, the Civil Division of the United States Attorney’s Office for the Southern District of Florida advised us that it is seeking documents and information from us and several of our affiliates relating to several matters including the coding of medical claims by one or more South Florida medical providers, and loans to physician practices. On May 1, 2014, the U.S. Attorney's Office filed a Notice of Non-Intervention in connection with a civil qui tam suit

related to one of these matters captioned United States of America ex rel. Olivia Graves v. Plaza Medical Centers, et al., and the Court ordered the complaint unsealed. Subsequently, the individual plaintiff amended the complaint and served the Company, opting to continue to pursue the action. After the Court dismissed her complaint, the individual plaintiff filed a second amended complaint on October 23, 2014, which all defendants answered and moved to dismiss, which motions are pending with the Court. We continue to cooperate with and respond to information requests from the U.S. Attorney's office. These matters could result in additional qui tam litigation.

Recently, the Civil Division of the United States Department of Justice provided us with an information request, separate from but related to the Plaza Medical matter, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, including the providers identified in the Plaza Medical matter, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice and the U.S. Attorney's Office.

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, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For example, a number of hospitals and other providers have asserted that, under their network provider contracts, we are not entitled to reduce Medicare Advantage payments to these providers in connection with changes in Medicare payment systems and in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as "sequestration"). Those challenges have led and could lead to arbitration demands or other litigation. Also, under state guaranty assessment laws, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

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

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extracontractual damages, care delivery malpractice, and claims arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive

damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for the contingencies discussed in both 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

On January 1, 2014, we reclassified certain of our businesses from our Healthcare Services segment to our Employer Group segment to correspond with internal management reporting changes. Our reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation.

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

The Retail segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, marketed directly to individuals, and includes our contract with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Employer Group segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary benefit products, as well as administrative services only, or ASO, products and our health and wellness products primarily marketed to employer groups. The Healthcare Services segment includes services offered to our health plan members as well as to third parties including pharmacy solutions, provider services, home based services, integrated behavioral health services, and predictive modeling and informatics services. The Other Businesses category consists of our military services, primarily our TRICARE South Region contract, Puerto Rico Medicaid, and closed-block long-term care insurance policies.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of RightSourceRx®, 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 managed care agreements with our health plans. Under these 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 and related administrative costs. Accordingly, our Healthcare Services segment reports provider services related revenues on a gross basis. Capitation fee revenue is recognized in the period in which the assigned members are entitled to receive healthcare services.

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 $9.7 billion in 2014, $7.3 billion in 2013, and $6.3 billion in 2012. 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 $116 million in 2014, $93 million in 2013, and $43 million in 2012. The increase in 2013 primarily was due to amortization expense associated with the December 21, 2012 acquisition of Metropolitan.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments consist of sales of services rendered by our Healthcare Services segment, primarily provider, pharmacy, and behavioral health services, to our Retail and Employer Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often utilize the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We 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 included with intersegment eliminations in the tables presenting segment results below.

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Our segment results were as follows for the years ended December 31, 2014, 2013, and 2012:

	Retail	Employer Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
	(in millions)					
2014						
Revenues—external customers						
Premiums:						
Medicare Advantage	$25,941	$5,490	$—	$—	$—	$31,431
Medicare stand-alone PDP	3,396	8	—	—	—	3,404
Total Medicare	29,337	5,498	—	—	—	34,835
Fully-insured	3,265	5,339	—	—	—	8,604
Specialty	256	1,098	—	—	—	1,354
Military services	—	—	—	19	—	19
Medicaid and other	1,096	—	—	51	—	1,147
Total premiums	33,954	11,935	—	70	—	45,959
Services revenue:						
Provider	—	23	1,183	—	—	1,206
ASO and other	39	339	—	481	—	859
Pharmacy	—	—	99	—	—	99
Total services revenue	39	362	1,282	481	—	2,164
Total revenues—external customers	33,993	12,297	1,282	551	—	48,123
Intersegment revenues						
Services	—	78	14,984	—	(15,062)	—
Products	—	—	3,749	—	(3,749)	—
Total intersegment revenues	—	78	18,733	—	(18,811)	—
Investment income	76	44	—	60	197	377
Total revenues	34,069	12,419	20,015	611	(18,614)	48,500
Operating expenses:						
Benefits	28,608	10,019	—	113	(574)	38,166
Operating costs	4,209	1,987	19,121	405	(18,083)	7,639
Depreciation and amortization	154	99	155	15	(90)	333
Total operating expenses	32,971	12,105	19,276	533	(18,747)	46,138
Income from operations	1,098	314	739	78	133	2,362
Interest expense	—	—	—	—	192	192
Income (loss) before income taxes	$1,098	$314	$739	$78	$(59)	$2,170

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 73% for 2014, compared to 75% for 2013 and 2012.

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	Retail	Employer Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
	(in millions)					
2013						
Revenues—external customers						
Premiums:						
Medicare Advantage	$22,481	$4,710	$—	$—	$—	$27,191
Medicare stand-alone PDP	3,025	8	—	—	—	3,033
Total Medicare	25,506	4,718	—	—	—	30,224
Fully-insured	1,160	5,117	—	—	—	6,277
Specialty	210	1,095	—	—	—	1,305
Military services	—	—	—	25	—	25
Medicaid and other	328	—	—	670	—	998
Total premiums	27,204	10,930	—	695	—	38,829
Services revenue:						
Provider	—	21	1,221	—	—	1,242
ASO and other	16	338	—	454	—	808
Pharmacy	—	—	59	—	—	59
Total services revenue	16	359	1,280	454	—	2,109
Total revenues—external customers	27,220	11,289	1,280	1,149	—	40,938
Intersegment revenues						
Services	—	51	11,808	—	(11,859)	—
Products	—	—	2,803	—	(2,803)	—
Total intersegment revenues	—	51	14,611	—	(14,662)	—
Investment income	74	42	—	59	200	375
Total revenues	27,294	11,382	15,891	1,208	(14,462)	41,313
Operating expenses:						
Benefits	22,914	9,124	—	935	(409)	32,564
Operating costs	2,963	1,806	15,223	446	(14,083)	6,355
Depreciation and amortization	134	102	147	20	(70)	333
Total operating expenses	26,011	11,032	15,370	1,401	(14,562)	39,252
Income (loss) from operations	1,283	350	521	(193)	100	2,061
Interest expense	—	—	—	—	140	140
Income (loss) before income taxes	$1,283	$350	$521	$(193)	$(40)	$1,921

Benefits expense for Other Businesses for 2013 includes $243 million for reserve strengthening associated with our closed block of long-term care insurance policies as discussed more fully in Note 18.

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	Retail	Employer Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
	(in millions)					
2012						
Revenues—external customers						
Premiums:						
Medicare Advantage	$20,788	$4,064	$—	$—	$—	$24,852
Medicare stand-alone PDP	2,853	8	—	—	—	2,861
Total Medicare	23,641	4,072	—	—	—	27,713
Fully-insured	1,004	4,996	—	—	—	6,000
Specialty	171	1,070	—	—	—	1,241
Military services	—	—	—	1,017	—	1,017
Medicaid and other	185	—	—	853	—	1,038
Total premiums	25,001	10,138	—	1,870	—	37,009
Services revenue:						
Provider	—	13	1,007	—	—	1,020
ASO and other	24	358	—	308	—	690
Pharmacy	—	—	16	—	—	16
Total services revenue	24	371	1,023	308	—	1,726
Total revenues—external customers	25,025	10,509	1,023	2,178	—	38,735
Intersegment revenues						
Services	2	31	9,680	—	(9,713)	—
Products	—	—	2,342	—	(2,342)	—
Total intersegment revenues	2	31	12,022	—	(12,055)	—
Investment income	79	42	—	58	212	391
Total revenues	25,106	10,582	13,045	2,236	(11,843)	39,126
Operating expenses:						
Benefits	21,048	8,471	—	1,802	(336)	30,985
Operating costs	2,767	1,710	12,530	436	(11,613)	5,830
Depreciation and amortization	130	89	87	16	(27)	295
Total operating expenses	23,945	10,270	12,617	2,254	(11,976)	37,110
Income (loss) from operations	1,161	312	428	(18)	133	2,016
Interest expense	—	—	—	—	105	105
Income (loss) before income taxes	$1,161	$312	$428	$(18)	$28	$1,911

18. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for approximately 2% of our consolidated premiums and services revenue for the year ended December 31, 2014. We use long-duration accounting for products such as long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

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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 interest rates, mortality, morbidity, 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, 2014 and 2013.

	2014		2013	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$167	$—	$166	$—
Trade accounts payable and accrued expenses	—	(68)	—	(67)
Long-term liabilities	—	(2,349)	—	(2,207)
Total asset (liability)	$167	$(2,417)	$166	$(2,274)

In addition, future policy benefits payable include amounts of $210 million at December 31, 2014 and $215 million at December 31, 2013 which are subject to 100% coinsurance agreements as more fully described in Note 19.

Benefits expense associated with future policy benefits payable was $32 million in 2014, $354 million in 2013, and $136 million in 2012. Benefits expense for 2013 included net charges of $243 million associated with our closed block of long-term care insurance policies discussed further below. Amortization of deferred acquisition costs included in operating costs was $39 million in 2014, $55 million in 2013, and $44 million in 2012.

Future policy benefits payable include $1.5 billion at December 31, 2014 and $1.4 billion at December 31, 2013 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was $123 million of additional liability at December 31, 2014 and no additional liability at December 31, 2013. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases and/or loss experience vary from our loss recognition date assumptions, future adjustments to reserves could be required.

During 2013, 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, 2010 loss recognition date, particularly as they related to emerging experience due to an increase in life expectancies and utilization of home health care services. Based on this deterioration, and combined with lower interest rates, 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 2013 we recorded $243 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $350 million partially offset by a related reinsurance recoverable of $107 million included in other long-term assets.

During 2012, we recorded a change in estimate associated with future policy benefits payable for our closed-block of long-term care insurance policies resulting in additional benefits expense of $29 million. This change in estimate was based on current claim experience demonstrating an increase in the length of the time policyholders already in payment status remained in such status. Future policy benefits payable was increased to cover future payments to policyholders currently in payment status.

Deferred acquisition costs included $59 million and $66 million associated with our individual commercial medical policies at December 31, 2014 and December 31, 2013, respectively. Future policy benefits payable associated with our individual commercial medical policies were $297 million at December 31, 2014 and $327 million at December 31, 2013.

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, long-term care, and annuities in run-off status, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods used to determine future policy benefits payable as detailed in Note 2. Excluding reinsurance associated with the Health Care Reform Law discussed in Note 2, reinsurance recoverables, included in other current and long-term assets, were $646 million at December 31, 2014 and $578 million at December 31, 2013. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 45% at December 31, 2014 and approximately 37% at December 31, 2013. Premiums ceded were $357 million in 2014, $33 million in 2013 and $34 million in 2012. Benefits ceded were $272 million in 2014, $70 million in 2013, and $86 million in 2012. Ceded premium and benefits in 2014 reflect a July 1, 2014 amendment ceding all risk under a Medicaid contract to a third party reinsurer.

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We evaluate the financial condition of these reinsurers on a regular basis. These reinsurers are well-known and well-established, as evidenced by the strong financial ratings at December 31, 2014 presented below: