UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

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

For the fiscal year ended December 31, 2021
or

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

For the transition period from _____ to _____

Commission file number 1-5975

HUMANA INC.
(Exact name of registrant as specified in its charter)

Delaware	**61-0647538**
(State or other jurisdiction of incorporation of organization)	(I.R.S. Employer Identification No.)

500 West Main Street, Louisville, Kentucky 40202
(Address of principal executive offices, and zip code)

Registrant's telephone number, including area code: **(502) 580-1000**

Securities registered pursuant to Section 12(b) of the Act:

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

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☑ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☑	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☑

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2021 was $56,778,277,553 calculated using the average price on June 30, 2021 of $442.72 per share.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2022 was 126,633,599.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant’s Definitive Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 21, 2022. Such Definitive Proxy Statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

HUMANA INC.
INDEX TO ANNUAL REPORT ON FORM 10-K
For the Year Ended December 31, 2021

Forward-Looking Statements

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

PART I

ITEM 1. BUSINESS

General

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

As of December 31, 2021, we had approximately 17 million members in our medical benefit plans, as well as approximately 5 million members in our specialty products. During 2021, 83% 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 769,100 members as of December 31, 2021.

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 2021 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2021 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Business Segments

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. The reportable segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer, the Chief Operating Decision Maker, to assess performance and allocate resources. See Note 18 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, include comprehensive managed care benefits generally through a participating network of physicians, hospitals, and other providers. Preferred provider organizations, or PPOs, provide members the freedom to choose any health care provider. However PPOs generally require the member to pay a greater portion of the provider’s fee in the event the member chooses not to use a provider participating in the PPO’s network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan’s network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, and home solutions, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2021:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 58,654	70.8 %
Group Medicare Advantage	6,955	8.4 %
Medicare stand-alone PDP	2,371	2.9 %
Total Retail Medicare	67,980	82.1 %
State-based Medicaid	5,109	6.2 %
Medicare Supplement	731	0.9 %
Total premiums	73,820	89.2 %
Services	23	— %
Total premiums and services revenue	$ 73,843	89.2 %

Medicare

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

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

Individual Medicare Advantage Products

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

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

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

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

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2021, 75% of the risk score was calculated from claims data submitted through EDS. CMS will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. For more information refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data and Item 1A. - Risk Factors.

At December 31, 2021, we provided health insurance coverage under CMS contracts to approximately 4,409,100 individual Medicare Advantage members, including approximately 769,100 members in Florida. These Florida contracts accounted for premiums revenue of approximately $11.9 billion, which represented approximately 20% of our individual Medicare Advantage premiums revenue, or 15% of our consolidated premiums and services revenue for the year ended December 31, 2021.

Our individual Medicare Advantage products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2022, and all of our product offerings filed with CMS for 2022 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, titled “Medicare Part D.” Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2022, and all of our product offerings filed with CMS for 2022 have been approved.

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

Group Medicare Advantage and Medicare stand-alone PDP

We offer products that enable employers that provide post-retirement health care benefits to replace Medicare wrap or Medicare supplement products with Medicare Advantage or stand-alone PDPs from Humana. These products are primarily offered as PPO plans on the same Medicare platform as individual Medicare Advantage plans. These plans offer the same types of benefits and services available to members in our individual Medicare plans discussed previously, however, group Medicare Advantage plans typically have richer benefit offerings than individual Medicare Advantage plans, including prescription drug coverage in the gap, for instance, due to the desire of many customers to closely match their pre-retirement benefit structure.

Medicare Supplement

We also offer Medicare supplement products that helps pay the medical expenses that Medicare FFS does not cover, such as copayments, coinsurance and deductibles.

State-based Medicaid Contracts

Through our state-based contracts, we serve members enrolled in Medicaid, a program funded by both the federal and state governments and administered by states to care for their most vulnerable populations. Within federal guidelines, states determine whom to cover, but general categories for traditional Medicaid programs include: children and parents receiving assistance through Temporary Assistance to Needy Families (TANF); Aged, Blind, and Disabled (ABD) individuals; and Medicaid Expansion adults. Through Medicaid Managed Long-Term Support Services (MLTSS) programs, states offer programs to deliver support services to people who receive home and community or institution-based services for long-term care.

We have contracts in multiple states to serve Medicaid-eligible members, including Florida, Kentucky, Ohio, South Carolina and Wisconsin.

We also serve members who qualify for both Medicaid and Medicare, referred to as "dual eligible", through our Medicaid, Medicare Advantage, and stand-alone prescription drug plans. As the dual eligible population represents a disproportionate share of costs, Humana is participating in varied integration models designed to improve health outcomes and reduce avoidable costs. These programs largely operate separately from traditional Medicaid programs. We currently serve dual eligible members under CMS's dual eligible demonstration program in Illinois.

As part of our individual Medicare Advantage products, we also offer Dual-Eligible Special Needs Plans (D-SNP). In connection with offering a D-SNP in a particular state, we are required to enter into a special coordinating contract with the applicable state Medicaid agency. To meet federal requirements that took effect in 2021, states have begun to implement new D-SNP requirements to strengthen Medicaid-Medicare integration requirements for D-SNPs. Some states are also moving to support the dual eligible population by linking D-SNP participation to enrollment in a plan that also participates in a state-based Medicaid program to coordinate and integrate both Medicare and Medicaid benefits.

Our Group and Specialty Segment Products

The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision and life insurance benefits, as well as administrative services only, or ASO products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group and Specialty segment by product for the year ended December 31, 2021:

	Group and Specialty Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 4,271	5.2 %
Specialty	1,731	2.1 %
Total premiums	6,002	7.3 %
Services	816	1.0 %
Total premiums and services revenue	$ 6,818	8.3 %
Intersegment services revenue	$ 40	n/a

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts.

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

Employers can customize their offerings with optional benefits such as dental, vision, and life products. We also offer optional benefits such as dental and vision to individuals.

Military Services

Under our TRICARE contracts with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. Under our contracts, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. On January 1, 2018, we began to deliver services under the T2017 East Region contract. The T2017 East Region contract comprises 32 states and approximately six million TRICARE beneficiaries. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022, unless extended, and is subject to renewals on January 1 of each year during its term at the government's option.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment includes pharmacy, provider, and home services, along with other services and capabilities to promote wellness and advance population health. The Healthcare Services segment also includes the operations of Kindred at Home (of which we recently acquired the remaining 60% ownership), as well as the company's strategic partnership with Welsh, Carson, Anderson & Stowe (WCAS) to develop and operate senior-focused, payor-agnostic, primary care centers are also included in the Healthcare Services segment. Services offered by this segment are designed to enhance the overall healthcare experience. These services may lead to lower utilization associated with improved member health and/or lower drug costs.

Our intersegment revenue is described in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2021:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Home solutions	$ 691	n/a
Pharmacy solutions	25,855	n/a
Provider services	2,476	n/a
Total intersegment revenue	$ 29,022	
External services revenue:		
Home solutions	$ 1,166	1.4 %
Pharmacy solutions	637	0.8 %
Provider services	413	0.5 %
Total external services revenue	$ 2,216	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 Humana Pharmacy, Inc.

Provider services

We operate full-service, multi-specialty medical centers in a number of states, including Georgia, Florida, Kansas, Louisiana, Missouri, Nevada, North Carolina, South Carolina, and Texas, staffed by primary care providers and medical specialists with a primary focus on the senior population under our Primary Care Organization, or PCO. PCO operates these clinics primarily under the Conviva and CenterWell brands. Our primary care subsidiaries operate our medical center business through both employed physicians and care providers, and through third party management service organizations with whom we contract to arrange for and manage certain clinical services. PCO currently operates 206 primary care clinics and employs or contracts with 1,001 primary care providers, serving approximately 352,800 patients, primarily under risk sharing arrangements with Humana Medicare Advantage health plans, third party Medicare Advantage health plans and CMS administered risk sharing arrangements for Original Medicare.

PCO also operates a Medical Services Organization, or MSO, through Conviva that coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. This MSO provides resources in care coordination, financial risk management, clinical integration and patient engagement that help physicians improve the patient experience as well as care outcomes. Conviva’s MSO collaborates with physicians, medical groups and integrated delivery systems to successfully transition to value-based care by engaging, partnering and offering practical services and solutions.

In the first quarter of 2020, our Primary Care Organization entered into a strategic partnership with Welsh, Carson, Anderson & Stowe, or WCAS, to accelerate the expansion of our primary care model. As of December 31, 2021, there were 31 primary care clinics operating under the partnership and we intend to open an additional 36 in future periods under the existing arrangement. See Note 4 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Home solutions

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. Now included in our Home solutions business is Kindred at Home, or KAH, which we fully acquired on August 17, 2021. KAH is the nation’s largest home health and hospice provider and has locations in 40 states, providing extensive geographic coverage with approximately 65% overlap with our individual Medicare Advantage membership. The KAH acquisition reflects our continued commitment to investing in home-based clinical solutions. When combined with KAH, our Home solutions geographic scale and clinical breadth provides the opportunity to offer care beyond our members. Fully integrating KAH's home health operations into our Home solutions business will allow us to accelerate clinical innovation and roll out a value-based operating model at scale, more closely aligning incentives to focus on improving patient outcomes and reducing the total cost of care. This is critical to deploying a value-based, advanced home health model at scale that makes it easier for patients and providers to benefit from our full continuum of home-based capabilities, leveraging the best channel to deliver the right care needed at the right time.

Hospice care is an important offering in the full continuum of care we intend to offer patients. However, we have been successful in delivering the desired patient experience and outcomes through partnership models, including through participation in the CMS hospice Value-Based Insurance Design, or VBID, model. As such, we continue to explore various alternatives for the long-term ownership structure of our Hospice business as part of our strategic investment. There is no assurance about the timing and certainty of any such transaction.

Also included in our Home solutions business are the operations of Humana At Home, Inc., or Humana At Home®. As chronic-care managers 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. The clinical support 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. Our care management programs include member enrollment in D-SNP plans, which are a large and growing part of our care management activities at Humana. Through these programs, care managers collaborate with physicians and other healthcare professionals to help patients manage their healthcare needs while addressing their physical, behavioral, cognitive, social and financial needs. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management and wellness programs. These programs use our capabilities that enable us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

For a detailed discussion of the KAH acquisition, please refer to Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Membership

The following table summarizes total medical membership in our Retail and Group and Specialty Segments at December 31, 2021, by market and product:

	Retail Segment					Group and Specialty Segment				
	(in thousands)									
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Medicare Supplement	State-based contracts and Other	Fully-insured commercial Group	ASO	Military services	Total	Percent of Total
Florida	769.1	7.4	162.0	17.9	704.5	121.3	37.3	—	1,819.5	10.7 %
Texas	354.3	4.2	244.0	27.2	2.1	99.5	38.2	—	769.5	4.5 %
Kentucky	115.2	70.9	162.5	8.6	168.8	85.9	138.4	—	750.3	4.4 %
Georgia	255.2	2.0	96.2	10.0	—	87.9	79.0	—	530.3	3.1 %
North Carolina	213.3	159.9	120.4	6.7	—	—	—	—	500.3	2.9 %
California	103.9	1.0	363.5	19.4	—	—	—	—	487.8	2.9 %
Illinois	154.8	27.6	139.7	7.4	17.5	20.8	38.4	—	406.2	2.4 %
Ohio	181.2	20.2	101.7	37.5	—	24.0	28.2	—	392.8	2.3 %
Missouri/Kansas	113.4	6.6	148.7	12.5	—	31.6	27.3	—	340.1	2.0 %
Tennessee	166.8	7.3	91.5	8.3	—	33.5	22.8	—	330.2	1.9 %
Louisiana	202.1	14.1	50.8	4.1	—	37.3	18.5	—	326.9	1.9 %
Wisconsin	72.4	6.4	80.7	7.7	42.6	44.5	26.1	—	280.4	1.6 %
Indiana	130.6	11.3	91.0	12.7	—	13.7	7.8	—	267.1	1.6 %
Virginia	141.1	3.8	105.1	7.6	—	—	—	—	257.6	1.5 %
Michigan	104.8	27.1	94.6	5.4	—	0.9	1.8	—	234.6	1.4 %
New York	93.4	10.7	117.1	8.5	—	—	—	—	229.7	1.3 %
Alabama	87.1	83.1	49.9	4.3	—	—	—	—	224.4	1.3 %
Pennsylvania	88.6	5.2	119.9	6.1	—	—	—	—	219.8	1.3 %
Arizona	111.9	0.3	71.4	9.0	—	14.6	7.0	—	214.2	1.3 %
Military services	—	—	—	—	—	—	—	6,049.0	6,049.0	35.4 %
Others	949.9	91.5	1,195.5	111.0	4.6	59.1	24.7	—	2,436.3	14.3 %
Totals	4,409.1	560.6	3,606.2	331.9	940.1	674.6	495.5	6,049.0	17,067.0	100.0 %

Provider Arrangements

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

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

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

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

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

Capitation

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

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

At December 31, 2021, approximately 1,654,000 members, or 9.7% of our medical membership, were covered under risk-based contracts, which provide all member benefits, including 1,427,100 individual Medicare Advantage members, or 32.4% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and measure the financial performance of our capitated providers and require guarantees in certain instances. However, we delegated claim processing functions under capitation arrangements covering approximately 247,200 HMO members, including 241,700 individual Medicare Advantage members, or 16.9% of the 1,427,100 individual Medicare Advantage members covered under risk-based contracts at December 31, 2021, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $2.4 billion, or 3.5% of total benefits expense, for the year ended December 31, 2021. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

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

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

Recredentialing of participating providers occurs every three years, unless otherwise required by state or federal regulations. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee composed of a peer group of providers reviews the applications of providers being considered for credentialing and recredentialing.

We maintain accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), and/or Utilization Review Accreditation Commission (URAC). Certain commercial businesses, such as those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, population health management, credentialing, utilization management, network management, and member experience. We have achieved and maintained NCQA accreditation in many of our commercial, Medicare and Medicaid HMO/POS and PPO markets and our wellness program, Go365. Humana's pharmacy organization is accredited by URAC.

Sales and Marketing

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

At December 31, 2021, we employed approximately 1,300 sales representatives, as well as approximately 1,500 telemarketing representatives who assisted in the marketing of Medicare products, including Medicare Advantage and PDP, in our Retail segment and specialty products in our Group and Specialty segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group and Specialty segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. We use licensed independent brokers, independent agents, digital insurance agencies, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our specialty products.

Underwriting

Since 2014, the Patient Protection and Affordability Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Health Care Reform Law, requires certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our individual Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2021 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system, including the Health Care Reform Law at the federal level and laws in certain states limiting the entry of new providers or services though a certificate of need, or CON, process.

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 2021 Form 10-K.

Certain Other Services

Captive Insurance Company

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

Centralized Management Services

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

Human Capital Management

Our associates are essential to our success in delivering on our core strategy, and creating positive healthcare experiences for our members. We are committed to recruiting, developing, and retaining strong, diverse teams, actively promoting a culture of inclusion and diversity. As of December 31, 2021, we had approximately 95,500 associates and approximately 1,400 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations.

Our Culture

We believe that our members' experience is linked to our associates' experience and that engaged, productive associates are the key to building a healthy company, creating a caring environment that enables our associates to go above and beyond for our members, driving innovation, and allowing for fulfilling experiences that incentivize them to stay with us over the long-term. Each year, we measure our success and opportunities to advance through our annual, third-party administered Associate Experience Survey. Results of the 2021 survey showed that 91% of associates are highly engaged. To continue to build on these results, we provide the survey results to our entire associate population and encourage leaders to use the information to create open, honest action plans with their teams to further deepen our collective engagement.

Inclusion and Diversity

Our associates' vast experiences and perceptions, their unique characteristics, backgrounds and beliefs, drive the groundbreaking, strategic thinking that gives our Company its competitive edge. We are committed to having balanced diversity at all levels of the Company and have developed a pathway for top, diverse talent within our recruiting initiatives. To achieve our recruiting and hiring goals we partner with local and national advocacy groups to provide information about open roles, assistance with resume preparation and application submission.

We have also incorporated balanced interview panels into our interview process, through which we strategically engage a broad spectrum of interviewers that bring greater diversity and perspective. This proven best practice strengthens the candidate experience and hiring of diverse talent, ensuring we get the right talent for any given role, and minimizes the potential for personal blind spots when evaluating candidates.

Pay and Benefits Philosophy, Compensation and Financial Security

Our Company's pay and benefits structure is designed to motivate and reward our associates at all levels of the organization for their skill development, demonstration of our values and performance. While our programs vary by location and business, they may include:

Financial	**Health**	**Life**
Competitive Base Pay	Medical, Dental and Vision Benefits	Paid time off, paid holidays and jury duty pay
Associate Incentive Plan (Annual Bonus)	Supplemental Health Benefits	Paid Parental Leave
Supplemental Pay (Including Overtime)	Long-term Care Insurance	Caregiver Time Off Program
Recognition Pay and Service Awards	Wellness and Rewards Program	Employee Assistance Program
401(k) Retirement Savings Plan with Company Match Program	Health Plan Incentives	Associate Discount Programs and Services
Life insurance	On-site Health and Fitness Centers	Helping Hands Program
Short- and Long-Term Disability Insurance	On-site Health Screenings and Vaccinations	Transit Services

Talent Development and Growth Opportunities

We champion the individual goals and development of our associates, and provide a number of programs to ensure that our associates have the resources and support they need to deliver on their passion. We provide opportunities for our associates to earn professional certifications through continued education programs and to participate in instructor-led and online courses designed to strengthen soft and hard-skills and enhance leadership development. Our Career Cultivation team sponsors workshops and events to promote associate accountability within their personal and professional growth as part of overall career development. Our associates are also encouraged to participate in mentoring programs with people of various backgrounds and cultures. We view mentoring as an essential development tool for sharing skills and knowledge so we can all succeed. Our commitment to mentoring feeds the successful future of our Company. Additionally, we utilize development programs to enhance talent within our organizations through targeted internal initiatives, where we aim to upskill and reskill existing associates for opportunities in new career pathways.

Additional information related to our human capital can be found by referencing our Definitive Proxy Statement of the Annual Meeting of Stockholders scheduled to be held on April 21, 2022 appearing under the captions "Human Capital Management."

Information About Our Executive Officers

Set forth below are names and ages of all of our current executive officers as of February 1, 2022, their positions, and the date first elected as an executive officer**:**

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	59	President and Chief Executive Officer, Director	12/11	(1)
Vishal Agrawal, M.D.	47	Chief Strategy and Corporate Development Officer	12/18	(2)
Heather M. Carroll Cox	51	Chief Digital Health and Analytics Officer	08/18	(3)
Samir M. Deshpande	57	Chief Information Officer	07/17	(4)
Susan M. Diamond	48	Chief Financial Officer	07/19	(5)
William K. Fleming, PharmD	54	Segment President, Pharmacy Solutions & Chief Corporate Affairs Officer	03/17	(6)
Timothy S. Huval	55	Chief Administrative Officer	12/12	(7)
Susan D. Schick	59	Segment President, Group and Military Business	09/21	(8)
William H. Shrank, M.D., MSHS	50	Chief Medical Officer	04/19	(9)
Joseph C. Ventura	45	Chief Legal Officer	02/19	(10)
T. Alan Wheatley	54	Segment President, Retail	03/17	(11)
Cynthia H. Zipperle	59	Senior Vice President, Chief Accounting Officer and Controller	12/14	(12)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Dr. Agrawal currently serves as Chief Strategy and Corporate Development Officer, having joined the Company in December 2018. Prior to joining the Company, Dr. Agrawal was Senior Advisor for The Carlyle Group L.P., having held that position from October 2017 to December 2018. Previously, Dr. Agrawal was President and Chief Growth Officer of Ciox Health, the largest health information exchange and release of information services organization in the U.S. from December of 2015 to October 2018. Prior to joining Ciox Health, Dr. Agrawal served as President of Harris Healthcare Solutions from January 2013 to December 2015.

(3) Ms. Cox currently serves as Chief Digital Health and Analytics Officer, having joined the Company in August 2018. Prior to joining the Company, Ms. Cox served as Chief Technology and Digital Officer at USAA, where she led the teams responsible for designing and building personalized and digitally-enabled end-to-end experiences for USAA members. Prior to USAA, Heather was the CEO of Citi FinTech at Citigroup, Inc., helping the company adapt to a future dominated by mobile technology, and she headed Card Operations, reshaping customer and digital experience for Capital One.

(4) Mr. Deshpande currently serves as Chief Information Officer, having been elected to this position in July 2021, from his prior role as Chief Technology and Risk Officer. Before joining the Company in July 2017, Mr. Deshpande spent 17 years at Capital One in key leadership positions, most recently as Business Chief Risk Officer for the U.S. and international card business. He previously served as the Business Chief Risk Officer and Head of Enterprise Services for the Financial Services Division, responsible for Business Risk, Data Science, Data Quality, Process Excellence and Project Management. He also led marketing and analysis for the Home Loans, Auto Finance, and Credit Card businesses, with responsibilities for business strategy, credit, product and marketing.

(5) Ms. Diamond currently serves as Chief Financial Officer, having been elected to this position in June 2021, from her prior role as Segment President, Home Business. Ms. Diamond joined the Company in June 2004 and has spent the majority of her career in various leadership roles in the Medicare and Home businesses, with a particular passion and emphasis on growth and consumer segmentation strategies for the Company's individual Medicare Advantage and Stand Alone Part D offerings. Ms. Diamond also served for two and a half years as the Enterprise Vice President of Finance, where she was responsible for enterprise planning and forecasting, trend analytics and had responsibility for each of the Company's line of business CFOs and controllers.

(6) Dr. Fleming currently serves as Segment President, Pharmacy Solutions and Chief Corporate Affairs Officer, having been elected to this position in July 2021, from his prior role as Segment President, Clinical and Pharmacy Solutions. Prior to that, Dr. Fleming held positions of Segment President, Healthcare Services as well as President of the Company's pharmacy business. Dr. Fleming joined the Company in 1994.

(7) Mr. Huval currently serves as Chief Administrative Officer, having been elected to this position in July 2019, from his previous role as Chief Human Resources Officer. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(8) Ms. Schick currently serves as Segment President, Group and Military Business, having been elected to this position in September 2021. Ms. Schick joined the Company in February 2020 in the role of Senior Vice President, Employer Group. Before she joined the Company, Ms. Schick spent 16 years in a range of senior-level leadership roles at United Healthcare in its Medicaid and Commercial businesses.

(9) Dr. Shrank currently serves as Chief Medical Officer, having been elected to this position in July 2021, from his previous role as Chief Medical and Corporate Affairs Officer. Before joining the Company in April 2019, Dr. Shrank served as Chief Medical Officer, Insurance Services Division at the University of Pittsburgh Medical Center, from 2016-2019, where he oversaw approximately $9 billion in annual health care expenditures for approximately 3.5 million members in Medicare, Medicaid, behavioral health, Managed Long Term Social Supports and commercial lines of business. He also developed and evaluated population health programs to further advance the medical center's mission as an integrated delivery and financing system. Prior to that, Dr. Shrank served as Senior Vice President, Chief Scientific Officer, and Chief Medical Officer of Provider Innovation at CVS Health from 2013 to 2016. Prior to joining CVS Health, Dr. Shrank served as Director, Research and Rapid-Cycle Evaluation Group, for the Center for Medicare and Medicaid Innovation, part of CMS from 2011 to 2013, where he led the evaluation of all payment and health system delivery reform programs and developed the rapid-cycle strategy to promote continuous quality improvement. Dr. Shrank began his career as a practicing physician with Brigham and Women's Hospital in Boston and as an Assistant Professor at Harvard Medical School. His research at Harvard focused on improving the quality of prescribing and the use of chronic medications. He has published more than 200 papers on these topics.

(10) Mr. Ventura currently serves as Chief Legal Officer. He joined the Company in January 2009 and since then has held various positions of increasing responsibility in the Company's Law Department, including most

recently, Senior Vice President, Associate General Counsel & Corporate Secretary from July 2017 until February 2019.

(11) Mr. Wheatley currently serves as Segment President, Retail, having held this position since March 2017. During his long-tenured career with the Company, Mr. Wheatley has served in a number of key leadership roles, including Vice President of Medicare Service Operations and President of the East Region, one of the Company's key Medicare geographies.

(12) Ms. Zipperle currently serves as Senior Vice President, Chief Accounting Officer and Controller, having held this position since December 2014. Ms. Zipperle previously served as the Vice President - Finance from January 2013 until election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

ITEM 1A. RISK FACTORS

Risks Relating to Our Business

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

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

- increased use of medical facilities and services, and the increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, prescription drugs, or new technologies;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- changes in our purchase discounts or pharmacy volume rebates received from drug manufacturers and wholesalers, which are generally passed on to clients in the form of steeper price discounts;
- catastrophes, including acts of terrorism, public health emergencies, epidemics or pandemics (such as the spread of COVID-19 or natural disasters (such as hurricanes and earthquakes) which could occur more frequently or with more intense effects as a result of the impact of global climate change;
- medical cost inflation; and
- government mandated benefits, member eligibility criteria, or other legislative, judicial, or regulatory changes.

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

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

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

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

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

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

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

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

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

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. The growth of our Medicare products is an important part of our business strategy, and the attendant concentration of revenues intensifies the risks to us inherent in Medicare products. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows.

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

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

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. These systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop and integrate new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences, and even with such resources there is no assurance that we will be able to do so. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to improve service levels or maintain effectively our information systems and data integrity, we could have operational disruptions, problems in determining medical cost estimates and establishing appropriate pricing, customer and health care provider disputes, regulatory or other legal problems, difficulty preventing and detecting fraud, have increases in operating expenses, loss of existing customers, difficulty in attracting new customers, or other adverse consequences, each of which may result in a material adverse effect on our results of operations, financial position, and cash flows.

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

We rely on our agreements with customers and service providers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows. The misappropriation of our proprietary information and/or third-party infringement claims against any software products we use could hinder our ability to market and sell products and services and may result in a material adverse effect on our results of operations, financial position and cash flows.

If we, and the third party service providers on whom we rely, 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 unintentional dissemination of sensitive personal information or proprietary or confidential information, we could be exposed to significant regulatory fines or

penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows.

In the ordinary course of our business, we process, store and transmit large amounts of data, and rely on third party service providers to do the same, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. We have been, and will likely continue to be, regular targets of attempted cybersecurity attacks and other security threats and may be subject to breaches of our information technology security systems. Although the impact of such attacks has not been material to our operations or results of operations, financial position, or cash flow through December 31, 2021, we can provide no assurance that we will be able to detect, prevent, or contain the effects of such cybersecurity attacks or other information security risks or threats in the future. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems, or the security of third party service providers, could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders.

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

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

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

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management, and offering of products and services. These include and could include in the future: claims relating to the methodologies for calculating premiums; claims relating to the denial of health care benefit payments; claims relating to the denial or rescission of insurance coverage; challenges to the use of some software products used in administering claims; claims relating to our administration of our Medicare Part D offerings; medical malpractice actions brought against our employed providers or affiliated physician-owned professional groups, based on our medical necessity decisions or brought against us on the theory that we are liable for a third-party providers' alleged malpractice; claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients; allegations of anti-competitive and unfair business activities; provider disputes over compensation or non-acceptance or termination of provider contracts; disputes related to ASO business, including actions alleging claim administration errors; false claims litigation, such as qui tam lawsuits, 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 or retained overpayments from the government, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model; claims related to the failure to disclose some business practices; claims relating to customer audits and contract performance; claims relating to dispensing of drugs associated with our in-house dispensing pharmacies; and professional liability claims arising out of the delivery of healthcare and related services to the public.

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

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

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

See "Legal Proceedings and Certain Regulatory Matters" in Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty.

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

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 89% of our total premiums and services revenue for the year ended December 31, 2021. These programs involve various risks, as described further below.

- At December 31, 2021, under our contracts with CMS we provided health insurance coverage to approximately 769,100 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, 2021. The loss of these and other CMS contracts (which are generally renewed annually) or significant changes in the Medicare Advantage and Prescription Drug Plan programs as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.
- At December 31, 2021, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2021, primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising 32 states and approximately six million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5 -year contract set to expire on December 31, 2022, unless extended, and is subject to renewals on January 1 of each year during its term at the government's option. The loss of the TRICARE T2017 East Region contract may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False

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

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

  CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2021, 75% of the risk score was calculated from claims data submitted through EDS. CMS will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

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

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We believe that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and have provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial position, or cash flows.

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

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

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

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net receivable of $106 million at December 31, 2021 and net receivable of $95 million at December 31, 2020.

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

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

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

Our business activities are subject to substantial government regulation. New laws or regulations, or legislative, judicial, or regulatory changes in existing laws or regulations or their manner of application could increase our cost of doing business and may have a material adverse effect on our results of operations, or cash flows.

The Health Care Reform Law and Other Current or Future Legislative, Judicial or Regulatory Changes

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the

U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases our effective tax rate, was in effect for calendar year 2020 and permanently repealed beginning in calendar year 2021.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative (including the Families First Coronavirus Response Act (the “Families First Act”), the Coronavirus Aid, Relief, and Economic Security Act (the “CARES Act”) and other legislative or regulatory action taken in response to COVID-19), judicial or regulatory changes, including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage business profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, increases in regulation of our prescription drug benefit businesses, or changes to the Part D prescription drug benefit design may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the Health Care Reform Law or declare all or certain portions of the Health Care Reform Law unconstitutional, create uncertainty for our business, and we cannot predict when, or in what form, such legislative changes or judicial determinations may occur.

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

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for the confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent. These regulations set standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures.

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened and strengthened the scope of the privacy and security regulations of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other requirements, the HITECH Act and HIPAA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

Corporate Practice of Medicine and Other Laws

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

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

We are subject to various federal and state healthcare fraud and abuse laws including the federal False Claims Act (the “False Claims Act”), the federal anti-kickback statute (the “Anti-Kickback Statute”), the federal “Stark Law,” and related state laws. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participating in the Medicare and Medicaid programs or other government healthcare programs. The False Claims Act prohibits knowingly submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. The Anti-Kickback Statute prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of business under Medicare or other governmental health program. The Stark Law prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services to any entity with which the physician, or an immediate family member of the physician, has a financial relationship, unless the financial relationship fits within a permissible exception.

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

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

State Regulation of our Products and Services

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

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

Certain of our healthcare services businesses require a Certificate of Need, or CON, to operate in certain states. These states restrict the entry of new providers or services and the expansion of existing providers or services in their state through a CON process, which is periodically evaluated and updated as required by applicable state law. To the extent that we require a CON or other similar approvals to expand our operations, our expansion could be adversely affected by our inability to obtain the necessary approval. To the extent laws in these CON states change, including the elimination of the CON requirement, the intangible value associated with these CONs may be impaired.

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

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

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

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

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

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

The success of our healthcare services businesses depends on our ability, and the ability of our affiliated physician-owned professional groups and management services organizations, to recruit, hire, acquire, contract with, and retain physicians, nurses and other medical professionals who are experienced in providing care services to older adults. The market to acquire or manage physician practices, and to employ or contract with individual physicians, nurses and other medical professionals is, and is expected to remain, highly competitive, and the performance of our healthcare services businesses may be adversely impacted if we, and our affiliated physician-owned professional groups and management services organizations, are unable to attract, maintain satisfactory relationships with, and retain physicians, nurses and other medical professionals, or if these businesses are unable to retain patients following the departure of a physician, nurses or other medical professional. In addition, our healthcare services businesses contract with competitors of our health benefits businesses, and these businesses could suffer if they are unable to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our businesses, operating results and/or future performance.

Our success depends on our ability to attract, develop and retain qualified employees and executives, including those with diverse backgrounds, experiences and skill sets, to operate and expand our business. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. In addition, while we have development and succession plans in place for our key employees and executives, these plans do not guarantee the services of our key employees and executives will continue to be available to us. If we are unable to attract, develop, retain and effectively manage the development and succession plans for key employees and executives, our business, results of operations and future performance could be adversely affected.

Our pharmacy business is highly competitive and subject us to regulations and distribution and supply chain risks in addition to those we face with our core health benefits businesses.

Our in-house dispensing pharmacy business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies.

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

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, including the application of state laws and regulations related to the operation of internet and mail-order pharmacies, violations of which could expose us to civil and criminal penalties, and manufacturing, distribution or other supply chain disruptions (including disruptions that occur as a result of catastrophes, including acts of terrorism, public health emergencies, epidemics or pandemics (such as the spread of COVID-19), or natural disasters (such as hurricanes and earthquakes) which could occur more frequently or with more intense effects as a result of the impacts of global climate change), each of which could impact the availability or cost of supplying of such products.

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

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

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

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

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

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

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

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

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

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, including the heightened uncertainty created by the COVID-19 pandemic, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

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

The spread of, and response to, COVID-19 underscores certain risks we face, including those discussed above, and the ongoing, heightened uncertainty created by the pandemic precludes any prediction as to the ultimate adverse impact to us of COVID-19.

COVID-19 underscores certain risks we face, including those discussed above. As the COVID-19 pandemic continues, the premiums we charge may prove to be insufficient to cover the cost of health care services delivered to our members, each of which could be impacted by many factors, including the impacts that we have experienced, and may continue to experience, to our revenues due to limitations on our ability to implement clinical initiatives to manage health care costs and chronic conditions of our members, and appropriately document their risk profiles, as a result of our members being unable or unwilling to see their providers due to actions taken to mitigate the spread of COVID-19; increased costs that may result from higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs; and shifts in our premium and medical claims cost trends to reflect the demographic impact of higher mortality during the COVID-19 pandemic. In addition, we are offering, and have been mandated by legislative and regulatory action (including the Families First Act and CARES Act) to provide, certain expanded benefit coverage to our members, such as waiving, or reimbursing, certain costs for COVID-19 testing, vaccinations and treatment. These measures taken by us, or governmental action, to respond to the ongoing impact of COVID-19 (including further expansion or modification of the services delivered to our members, the adoption or modification of regulatory requirements associated with those services and the costs and challenges associated with ensuring timely compliance with such requirements), and the potential for widespread testing, treatments and the distribution and administration of COVID-19 vaccines, could adversely impact our profitability.

The spread and impact of COVID-19 and additional variants, or actions taken to mitigate this spread, could have material and adverse effects on our ability to operate effectively, including as a result of the complete or partial closure of facilities or labor shortages. Disruptions in public and private infrastructure, including communications, availability of in-person sales and marketing channels, financial services and supply chains, could materially and adversely disrupt our normal business operations. A significant subset of our and our third party providers' employee populations are in a remote work environment in an effort to mitigate the spread of COVID-19, which may exacerbate certain risks to our business, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, and increased risk of unauthorized dissemination of sensitive personal, or proprietary and/or confidential information. The continued COVID-19 pandemic has severely impacted global economic activity, including the businesses of some of our commercial customers, and caused significant volatility and negative pressure in the financial markets. In addition to disrupting our operations, these developments may adversely affect the timing of commercial customer premium collections and corresponding claim payments, the value of our investment portfolio, or future liquidity needs.

The ongoing, heightened uncertainty created by the pandemic precludes any prediction as to the ultimate adverse impact to us of COVID-19. We are continuing to monitor the spread of COVID-19, changes to our benefit coverages, and the ongoing costs and business impacts of dealing with COVID-19, including the potential costs and impacts associated with lifting, or reimposing, restrictions on movement and economic activity, the timing and degree in resumption of demand for deferred healthcare services, the pace of administration of COVID-19 vaccines and the effectiveness of those vaccines, and related risks. The magnitude and duration of the pandemic remains uncertain, and its ultimate impact on our business, results of operations, financial position, and cash flows could be material.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

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

We owned or leased numerous medical centers and administrative offices at December 31, 2021. The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of these medical centers, approximately 221 of these facilities are leased or subleased to our contracted providers to operate.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, qui tam litigation brought by individuals seeking to sue on behalf of the government, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see “Legal Proceedings and Certain Regulatory Matters” in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM.

Holders of our Capital Stock

As of January 31, 2022, there were 1,804 holders of record of our common stock and 404,351 beneficial holders of our common stock.

Dividends

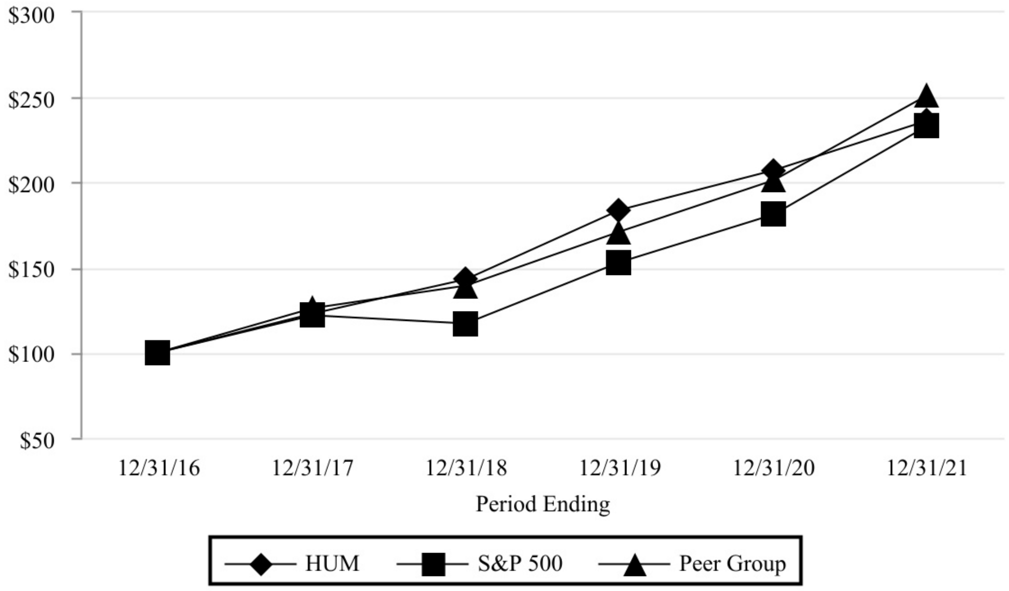
The following table provides details of dividend payments, excluding dividend equivalent rights, in 2020 and 2021, under our Board approved quarterly cash dividend policy:

Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2020 payments			
12/31/2019	1/31/2020	$0.550	$73
3/31/2020	4/24/2020	$0.625	$83
6/30/2020	7/31/2020	$0.625	$83
9/30/2020	10/30/2020	$0.625	$83
2021 payments			
12/31/2020	1/29/2021	$0.625	$81
3/31/2021	4/30/2021	$0.700	$90
6/30/2021	7/30/2021	$0.700	$90
9/30/2021	10/29/2021	$0.700	$90

In October 2021, the Board declared a cash dividend of $0.70 per share payable on January 28, 2022 to stockholders of record on December 31, 2021 for an aggregate amount of $90 million. In February 2022, the Board declared a cash dividend of $0.7875 per share payable on April 29, 2022 to stockholders of record on March 31, 2022. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2021. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2015, and that dividends were reinvested when paid.



	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021
HUM	$ 100	$ 123	$ 143	$ 184	$ 207	$ 236
S&P 500	$ 100	$ 122	$ 117	$ 153	$ 181	$ 233
Peer Group	$ 100	$ 126	$ 139	$ 171	$ 201	$ 251

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

Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2021 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1) (2)
October 2021	—	$ —	—	$ 3,000,000,000
November 2021	—	—	—	3,000,000,000
December 2021	—	—	—	3,000,000,000
Total	—	$ —	—	

(1) On February 18, 2021, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on February 18, 2024, exclusive of shares repurchased in connection with employee stock plans. Under the share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions, including pursuant to accelerated share repurchase agreements with investment banks, subject to certain regulatory restrictions on volume, pricing, and timing.

(2) Excludes 0.2 million shares repurchased in connection with employee stock plans.

ITEM 6. SELECTED FINANCIAL DATA

Not applicable.

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

For discussion of 2019 items and year-over-year comparisons between 2020 and 2019 that are not included in this 2021 Form 10-K, refer to "Item 7. – Management Discussion and Analysis of Financial Condition and Results of Operations" found in our Form 10-K for the year ended December 31, 2020, that was filed with the Securities and Exchange Commission on February 18, 2021.

Executive Overview

General

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

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

Kindred at Home Acquisition

On August 17, 2021, we acquired the remaining 60% interest in Kindred at Home, or KAH, the nation’s largest home health and hospice provider, from TPG Capital and Welsh, Carson, Anderson & Stowe, two private equity funds, for an enterprise value of $8.2 billion, which includes our equity value of $2.4 billion associated with our 40% minority ownership interest. The remeasurement to fair value of our previously held 40% equity method investment with a carrying value of approximately $1.3 billion, resulted in a $1.1 billion gain recognized in "Other (income) expense, net". KAH has locations in 40 states, providing extensive geographic coverage with approximately 65% overlap with our individual Medicare Advantage membership. We paid the approximate $5.8 billion transaction price (net of our existing equity stake) through a combination of debt financing, the assumption of existing KAH indebtedness and parent company cash.

COVID-19

The emergence and spread of the novel coronavirus, or COVID-19, beginning in the first quarter of 2020 has impacted our business. During periods of increased incidences of COVID-19, non-essential care from a reduction in non-COVID-19 hospital admissions and lower overall healthcare system consumption decreased utilization. At the same time, COVID-19 treatment and testing costs increased utilization. The significant disruption in utilization during 2020 also impacted our ability to implement clinical initiatives to manage health care costs and chronic conditions of our members, and appropriately document their risk profiles, and, as such, significantly affected our 2021 revenue under the risk adjustment payment model for Medicare Advantage plans. Finally, changes in utilization patterns and actions taken in 2020 and 2021 as a result of the COVID-19 pandemic, including the suspension of certain financial recovery programs for a period of time and shifting the timing of claim payments and provider capitation surplus payments, impacted our claim reserve development and operating cash flows for 2020 and 2021.

Business Segments

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. The reportable segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer, the Chief Operating Decision Maker, to assess performance and allocate resources. See Note 18 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible demonstration, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes our military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes pharmacy, provider, and home services, along with other services and capabilities to promote wellness and advance population health. The operations of the recently acquired full ownership of Kindred at Home, as well as the company's strategic partnership with Welsh, Carson, Anderson & Stowe (WCAS) to develop and operate senior-focused, payor-agnostic, primary care centers are also included in the Healthcare Services segment.

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

Seasonality

COVID-19 disrupted the pattern of our quarterly earnings and operating cash flows largely due to the temporary deferral of non-essential care which resulted in reductions in non-COVID-19 hospital admissions and lower overall healthcare system utilization during higher levels of COVID-19 hospital admissions. At the same time, during periods of increased incidences of COVID-19, COVID-19 treatment and testing costs increase. Similar impacts and seasonal disruptions from either higher or lower utilization are expected to persist as we respond to and recover from the COVID-19 global health crisis.

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

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

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

Highlights

- Our strategy offers our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2021, approximately 3,009,600 members, or 68%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 2,650,100 members, or 67%, at December 31, 2020.

- In order to create capacity to fund growth and investment in our Medicare Advantage business and further expand our Healthcare Services capability in 2023, we committed to efforts to create additional value through cost savings, productivity initiatives and value acceleration from previous investments. As a result of these initiatives, we anticipate that we may incur certain charges in 2022.

- On February 2, 2022, Centers for Medicare & Medicaid Services, or CMS, issued its preliminary 2023 Medicare Advantage and Part D payment rates and proposed policy changes, collectively, the Advance Notice. CMS has invited public comment on the Advance Notice before publishing final rate on or before April 4, 2022, or the Final Notice. In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 4.48% increase in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee-for-service county rebasing/re-pricing since the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. Further the benchmark increase excludes MA risk score trend as individual plans' experience will vary. Based on the company's preliminary analysis using the same factors CMS included in its estimate, the components of which are detailed on CMS's website, we anticipate the proposals in the Advance Notice would result in a change generally in line with CMS's estimate. The company will be drawing upon its program expertise to provide CMS formal commentary on the impact of the Advance Notice and the related impact on Medicare beneficiaries' quality of care and service to its members through the Medicare Advantage program.

- Net income was $2.9 billion, or $22.67 per diluted common share, and $3.4 billion, or $25.31 per diluted common share, in 2021 and 2020, respectively. This comparison was significantly impacted by the gain on our equity method investment in Kindred at Home upon completion of our acquisition of the business, put/call valuation adjustments associated with our non consolidating minority interest investments, the change in the fair value of publicly-traded equity securities, transaction and integration costs associated with the Kindred at Home acquisition, and the receipt of unpaid risk corridor payments in the third quarter of 2020 that were previously written off. The put/call valuation adjustments included the impact of the termination of the put/call agreement related to Kindred at Home as a result of the signing of the definitive agreement for the transaction on April 27, 2021. The impact of these adjustments to our consolidated income before income taxes and equity in net earnings and diluted earnings per common share was as follows for 2021.

	2021	2020
	(in millions)	
Consolidated income before income taxes and equity in net earnings:		
Gain on Kindred at Home equity method investment	$ 1,129	$ —
Put/call valuation adjustments associated with company's non consolidating minority interest investments	(597)	(103)
Transaction and integration costs associated with Kindred at Home acquisition	(128)	—
Change in the fair value of publicly-traded equity securities	(341)	745
Receipt of commercial risk corridor receivables previously written-off	—	578
	$ 63	$ 1,220

	2021	2020
Diluted earnings per common share:		
Gain on Kindred at Home equity method investment	$ 8.73	$ —
Put/call valuation adjustments associated with company's non consolidating minority interest investments	(3.56)	(0.60)
Transaction and integration costs associated with Kindred at Home acquisition	(0.72)	—
Change in the fair value of publicly-traded equity securities	(2.03)	4.32
Receipt of commercial risk corridor receivables previously written-off	—	3.35
	$ 2.42	$ 7.07

- Excluding these adjustments, comparisons of our results of operations were materially impacted by the significant, temporary deferral of care in 2020 resulting from stay-at-home orders, physical distancing measures, and other restrictions implemented to reduce the spread of COVID-19, as well as the impact of COVID-19 testing and treatment costs, which on a net basis significantly and favorably impacted the 2020 period results when compared to the 2021 period results. In addition, the 2021 period results reflect the impact of lower COVID-19 related administrative costs in 2021 compared to 2020. Administrative costs in 2020 included costs associated with personal protective equipment, member response effort, the build-out of infrastructure necessary to support employees working remotely and charitable contribution cost to support the communities served by us. Combined, the COVID-19 impacts described previously resulted in lower operating results in 2021 compared to 2020.

- Partially offsetting the COVID-19 financial headwind that we experienced in 2021, our results of operations for 2021 were favorably impacted by individual Medicare Advantage and state-based contract membership growth and improved operating performance in our Healthcare Services segment, including the consolidation of Kindred at Home operations upon completion of the acquisition of the remaining 60% interest in Kindred at Home in August 2021. Further, 2021 was also favorably impacted by the lower tax rate resulting from the termination of the non-deductible health insurance industry fee in 2021, as well as a lower number of shares used to compute dilutive earnings per common share, primarily reflecting share repurchases.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases our effective tax rate, was in effect for calendar year 2020 and permanently repealed beginning in calendar year 2021.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative, judicial or regulatory changes such as the Families First Coronavirus Response Act (the "Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and other legislative or regulatory action taken in response to COVID-19 including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, or increases in regulation of our prescription drug benefit businesses, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home services, to our Retail and Group and Specialty segment customers and are described in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data in this 2021 Form 10-K.

Comparison of Results of Operations for 2021 and 2020

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2021 and 2020:

Consolidated

	2021	2020	Change Dollars	Change Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 73,820	$ 67,124	$ 6,696	10.0 %
Group and Specialty	6,002	6,460	(458)	(7.1)%
Corporate	—	602	(602)	(100.0)%
Total premiums	79,822	74,186	5,636	7.6 %
Services:				
Retail	23	19	4	21.1 %
Group and Specialty	816	780	36	4.6 %
Healthcare Services	2,216	1,016	1,200	118.1 %
Total services	3,055	1,815	1,240	68.3 %
Investment income	187	1,154	(967)	(83.8)%
Total revenues	83,064	77,155	5,909	7.7 %
Operating expenses:				
Benefits	69,199	61,628	7,571	12.3 %
Operating costs	10,121	10,052	69	0.7 %
Depreciation and amortization	596	489	107	21.9 %
Total operating expenses	79,916	72,169	7,747	10.7 %
Income from operations	3,148	4,986	(1,838)	(36.9)%
Interest expense	326	283	43	15.2 %
Other (income) expense, net	(532)	103	635	616.5 %
Income before income taxes and equity in net earnings	3,354	4,600	(1,246)	(27.1)%
Provision for income taxes	485	1,307	(822)	(62.9)%
Equity in net earnings	65	74	(9)	(12.2)%
Net income	$ 2,934	$ 3,367	$ (433)	(12.9)%
Diluted earnings per common share	$ 22.67	$ 25.31	$ (2.64)	(10.4)%
Benefit ratio (a)	86.7 %	83.1 %		3.6 %
Operating cost ratio (b)	12.2 %	13.2 %		(1.0)%
Effective tax rate	14.2 %	28.0 %		(13.8)%

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

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

Premiums Revenue

Consolidated premiums increased $5.6 billion, or 7.6%, from $74.2 billion in the 2020 period to $79.8 billion in the 2021 period primarily due to higher premium revenues from Medicare Advantage and state-based contracts membership growth, higher per member Medicare Advantage premiums as a result of the improving CMS benchmark rate for 2021, net of Medicare Risk Adjustment (MRA) headwinds resulting from COVID-19 related utilization disruption in 2020, as well as the additional quarter impact of Medicare sequestration relief in 2021 that was not enacted until the second quarter of 2020. These increases were partially offset by declining stand-alone PDP, group commercial medical, and group Medicare Advantage membership as more fully described in the detailed segment results discussion that follows, as well as the 2020 impact of the receipt of commercial risk corridor receivables previously written off.

Services Revenue

Consolidated services revenue increased $1.2 billion, or 68.3%, from $1.8 billion in the 2020 period to $3.1 billion in the 2021 period primarily due to higher home solutions revenues associated with consolidation of Kindred at Home earnings.

Investment Income

Investment income decreased $967 million, or 83.8%, from $1.2 billion in the 2020 period to $187 million in the 2021 period primarily due to a significant decrease in the fair value of our publicly-traded equity securities investments.

Benefits Expense

Consolidated benefits expense increased $7.6 billion, or 12.3%, from $61.6 billion in the 2020 period to $69.2 billion in the 2021 period. The consolidated benefit ratio increased 360 basis points from 83.1% in the 2020 period to 86.7% in the 2021 period. These increases reflect the termination in 2021 of the non-deductible health insurance industry fee which, along with a portion of the related tax benefit, was contemplated in the pricing and benefit design of our products, and COVID-19 impacts, including the impact of the deferral of non-essential care, net of meaningful COVID-19 treatment and testing costs, our pandemic relief efforts in 2020, as well as 2021 MRA headwinds resulting from this COVID-19 related utilization disruption in 2020. The year over year increase further reflects the 2020 impact of the receipt of commercial risk corridor receivables that were previously written off, and the 2021 impact associated with the competitive nature of the group Medicare Advantage business, particularly in large group accounts that were recently procured, as well as in the stand-alone PDP business. These factors were partially offset by higher favorable prior-period medical claims reserve development in 2021.

The higher favorable prior-period medical claims reserve development was primarily attributable to the reversal of actions taken in 2020, including the suspension of certain financial recovery programs for a period of time impacting our claim payment patterns. The suspension during 2020 was intended to provide financial and administrative relief for providers facing unprecedented strain as a result of the COVID-19 pandemic. The favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 100 basis points in the 2021 period versus approximately 40 basis points in the 2020 period.

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 $0.07 billion, or 0.7%, from $10.05 billion in the 2020 period to $10.12 billion in the 2021 period. The consolidated operating cost ratio decreased 100 basis points from 13.2% in the 2020 period to 12.2% in the 2021 period. The ratio decrease was primarily due to the termination of the non-deductible health insurance industry fee in 2021, as well as lower COVID-19 related administrative costs in 2021 compared to 2020. Administrative costs in 2020 included costs associated with personal protective equipment, member response efforts, and the build-out of infrastructure necessary to support employees working remotely. The decrease was further impacted by scale efficiencies associated with growth in our individual Medicare Advantage membership, operating cost efficiencies in 2021 from previously implemented productivity initiatives, as well as the impact of a $200 million contribution to the Humana Foundation in the first half of 2020 to support communities served by the Company, particularly those with social and health disparities. These factors were partially offset by the consolidation of Kindred at Home operations as the business has a significantly higher operating cost ratio than our historical consolidated operating cost ratio, continued strategic and technology modernization investments made to position us for long-term success, transaction and integration costs associated with the Kindred at Home transaction, as well as the 2020 impact of the receipt of the commercial risk corridor receivables that were previously written off. The non-deductible health insurance industry fee impacted the operating cost ratio by 160 basis points in the 2020 period.

Depreciation and Amortization

Depreciation and amortization increased $107 million, or 21.9%, from $489 million in the 2020 period to $596 million in the 2021 period primarily due to capital expenditures.

Interest Expense

Interest expense increased $43 million, or 15.2%, from $283 million in the 2020 period to $326 million in the 2021 period from borrowings to fund the KAH acquisition.

Income Taxes

Our effective tax rate during 2021 was 14.2% compared to the effective tax rate of 28.0% in 2020. The change was primarily due to the non-taxable gain we recognized on our previously held Kindred at Home equity method investment from our acquisition of the remaining ownership interest in the business in August 2021 and the termination of the non-deductible health insurance industry fee in 2021. See Note 12 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

			Change	
	2021	**2020**	**Members**	**Percentage**
Membership:				
Medical membership:				
Individual Medicare Advantage	4,409,100	3,962,700	446,400	11.3 %
Group Medicare Advantage	560,600	613,200	(52,600)	(8.6)%
Medicare stand-alone PDP	3,606,200	3,866,700	(260,500)	(6.7)%
Total Retail Medicare	8,575,900	8,442,600	133,300	1.6 %
State-based Medicaid	940,100	772,400	167,700	21.7 %
Medicare Supplement	331,900	335,600	(3,700)	(1.1)%
Total Retail medical members	9,847,900	9,550,600	297,300	3.1 %

	2021	2020	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 58,654	$ 51,697	$ 6,957	13.5 %
Group Medicare Advantage	6,955	7,774	(819)	(10.5)%
Medicare stand-alone PDP	2,371	2,742	(371)	(13.5)%
Total Retail Medicare	67,980	62,213	5,767	9.3 %
State-based Medicaid	5,109	4,223	886	21.0 %
Medicare Supplement	731	688	43	6.3 %
Total premiums	73,820	67,124	6,696	10.0 %
Services	23	19	4	21.1 %
Total premiums and services revenue	$ 73,843	$ 67,143	$ 6,700	10.0 %
Segment earnings	$ 1,937	$ 3,017	$ (1,080)	(35.8)%
Benefit ratio	87.9 %	84.2 %		3.7 %
Operating cost ratio	9.2 %	11.0 %		(1.8)%

Segment Earnings

- Retail segment earnings decreased $1.1 billion, or 35.8%, from $3.0 billion in the 2020 period to $1.9 billion in the 2021 period primarily due to the same factors reflecting the segment's higher benefit ratio, partially offset by the segment's lower operating cost ratio as more fully described below.

Enrollment

- Individual Medicare Advantage membership increased 446,400 members, or 11.3%, from 3,962,700 members as of December 31, 2020 to 4,409,100 members as of December 31, 2021 primarily due to membership additions associated with the previous Annual Election Period, or AEP, and Open Election Period, or OEP, for Medicare beneficiaries. The membership growth was further impacted by continued enrollment resulting from special elections, age-ins, and Dual Eligible Special Need Plans, or D-SNP, members. The OEP sales period, which ran from January 1 to March 31, 2021 added approximately 36,000 members compared to the 2020 OEP that added approximately 30,000 members. Individual Medicare Advantage membership includes 576,100 D-SNP members as of December 31, 2021, a net increase of 170,000 members, or 42%, from 406,100 members as of December 31, 2020. For the full year 2022, we anticipate a net membership growth in our individual Medicare Advantage offerings of approximately 150,000 to 200,000 members.

- Group Medicare Advantage membership decreased 52,600 members, or 8.6%, from 613,200 members as of December 31, 2020 to 560,600 members as of December 31, 2021 primarily due to the net loss of certain large accounts in January 2021, partially offset by continued growth in small group accounts. For the full year 2022, we anticipate relatively flat membership growth.

- Medicare stand-alone PDP membership decreased 260,500 members, or 6.7%, from 3,866,700 members as of December 31, 2020 to 3,606,200 members as of December 31, 2021 primarily due to anticipated declines as a result of the Walmart Value plan no longer being the low cost leader in 2021. For the full year 2022, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of approximately 125,000 members.

- State-based Medicaid membership increased 167,700 members, or 21.7%, from 772,400 members as of December 31, 2020 to 940,100 members as of December 31, 2021 primarily reflecting additional enrollment as a result of the suspension of state eligibility redetermination efforts due to the currently-enacted Public Health Emergency, as well as the recently completed acquisition of our remaining 50% ownership interest in Wisconsin health care company iCare. For the full year 2022, we anticipate a net membership decline in our state-based contracts of approximately 50,000 to 100,000 members assuming the Public Health Emergency will end in April 2022.

Premiums revenue

- Retail segment premiums increased $6.7 billion, or 10.0%, from $67.1 billion in the 2020 period to $73.8 billion in the 2021 period primarily due to higher premiums as a result of individual Medicare Advantage and state-based contracts membership growth, higher per member individual Medicare Advantage premiums as a result of the improving CMS benchmark rate for 2021, net of MRA headwinds resulting from COVID-19 related utilization disruption in 2020, as well as the additional quarter impact of Medicare sequestration relief in 2021 that was not enacted until the second quarter of 2020. These favorable items were partially offset by the decline in membership in our stand-alone PDP and group Medicare Advantage offerings.

Benefits expense

- The Retail segment benefit ratio increased 370 basis points from 84.2% in the 2020 period to 87.9% in the 2021 period primarily due to the termination in 2021 of the non-deductible health insurance industry fee which, along with a portion of the related tax benefit, was contemplated in the pricing and benefit design of our products, COVID-19 impacts, including the impact of the deferral of non-essential care, net of meaningful COVID-19 treatment and testing costs, our pandemic relief efforts in 2020, as well as 2021 MRA headwinds resulting from this COVD-19 related utilization disruption in 2020. Also contributing to the higher benefit ratio was the 2021 impact of the competitive nature of the group Medicare Advantage business, particularly in large group accounts that were recently procured, as well as in the stand-alone PDP business. These factors were partially offset by higher favorable prior-period medical claims reserve development.

- The Retail segment's benefits expense for the 2021 period includes the beneficial effect of $729 million in favorable prior-year medical claims reserve development versus $266 million in 2020. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 100 basis points in 2021 versus approximately 40 basis points in 2020. The higher favorable prior-period medical claims reserve development was primarily attributable to the reversal of actions taken in 2020, including the suspension of certain financial recovery programs for a period of time impacting our claim payment patterns. The suspension during 2020 was intended to provide financial and administrative relief for providers facing unprecedented strain as a result of the COVID-19 pandemic.

Operating costs

- The Retail segment operating cost ratio decreased 180 basis points from 11.0% in the 2020 period to 9.2% in the 2021 period primarily due to the termination of the non-deductible health insurance industry fee in 2021, lower COVID-19 related administrative costs, as previously discussed, scale efficiencies associated with growth in our individual Medicare Advantage membership, as well as operating cost efficiencies driven by previously implemented productivity initiatives. These improvements were partially offset by continued strategic investments made in 2021 to position us for long-term success. The non-deductible health insurance industry fee impacted the operating cost ratio by 160 basis points in the 2020 period.

Group and Specialty Segment

	2021	2020	Change: Members	Change: Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	674,600	777,400	(102,800)	(13.2)%
ASO	495,500	504,900	(9,400)	(1.9)%
Military services	6,049,000	5,998,700	50,300	0.8 %
Total group medical members	7,219,100	7,281,000	(61,900)	(0.9)%
Specialty membership (a)	5,294,300	5,310,300	(16,000)	(0.3)%

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

	2021	2020	Change: Dollars	Change: Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 4,271	$ 4,761	$ (490)	(10.3)%
Specialty	1,731	1,699	32	1.9 %
Total premiums	6,002	6,460	(458)	(7.1)%
Services	816	780	36	4.6 %
Total premiums and services revenue	$ 6,818	$ 7,240	$ (422)	(5.8)%
Segment earnings (loss)	$ 149	$ (143)	$ 292	204.2 %
Benefit ratio	82.5 %	85.6 %		(3.1)%
Operating cost ratio	24.6 %	25.0 %		(0.4)%

Segment Earnings

- Group and Specialty segment earnings increased $292 million, or 204.2%, from a $143 million loss in the 2020 period to $149 million of earnings in the 2021 period primarily due to the same factors reflecting the segment's lower benefit ratio and operating cost ratio as more fully described below.

Enrollment

- Fully-insured commercial group medical membership decreased 102,800 members, or 13.2%, from 777,400 members as of December 31, 2020 to 674,600 members as of December 31, 2021 reflecting lower small group quoting activity and sales attributable to depressed economic activity from the COVID-19 pandemic, partially offset by higher retention of existing customers, particularly in larger groups. The portion of group fully-insured commercial medical membership in small group accounts was approximately 50% at December 31, 2021 and 54% at December 31, 2020.

- Group ASO commercial medical membership decreased 9,400 members, or 1.9%, from 504,900 members as of December 31, 2020 to 495,500 members as of December 31, 2021. Small group membership comprised 43% of group ASO medical membership at December 31, 2021 and 45% at December 31, 2020. The membership change reflects intensified competition for small group accounts, partially offset by strong retention among large group accounts. For the full year 2022, we anticipate a net membership decline in our group commercial medical offerings, which includes fully-insured and ASO, of approximately 125,000 to 165,000 members.

- Military services membership increased 50,300 members, or 0.8%, from 5,998,700 members as of December 31, 2020 to 6,049,000 members as of December 31, 2021. Membership includes military service members, retirees, and their families to whom we are providing healthcare services under the current TRICARE East Region contract.

- Specialty membership decreased 16,000 members, or 0.3%, from 5,310,300 members as of December 31, 2020 to 5,294,300 members as of December 31, 2021 primarily due to the loss of dental and vision groups cross-sold with medical, as reflected in the loss of group fully-insured commercial medical membership described above. The decrease also reflects the impact of the economic downturn driven by the COVID-19 pandemic.

Premiums revenue

- Group and Specialty segment premiums decreased $458 million, or 7.1%, from $6.5 billion in the 2020 period to $6.0 billion in the 2021 period primarily due to the decline in our fully-insured group commercial membership, partially offset by higher per member premiums across the fully-insured commercial business.

Services revenue

- Group and Specialty segment services revenue increased $36 million, or 4.6%, from $780 million in the 2020 period to $816 million in the 2021 period primarily due to higher TRICARE services revenue partially offset by lower ASO membership described previously.

Benefits expense

- The Group and Specialty segment benefit ratio decreased 310 basis points from 85.6% in the 2020 period to 82.5% in the 2021 period. The decrease reflects the negative COVID-19 impacts in 2020 including meaningful COVID-19 treatment and testing costs along with our ongoing pandemic relief efforts, primarily surrounding initiatives to ease administrative and financial stress for providers and employers, net of the impact of the deferral of non-essential care. The comparison was further impacted by the deliberate pricing and benefit design efforts in 2021 to increase profitability and position the commercial business for long-term success, lower specialty utilization, primarily related to dental services in 2021, as well as the beneficial impact of higher favorable prior-period medical claims reserve development in the 2021 period. These favorable comparisons were partially offset by the termination in 2021 of the non-deductible health insurance industry fee in which, along with a portion of the related tax benefit, was contemplated in the pricing and benefit design of our products.

- The Group and Specialty segment’s benefits expense includes the beneficial effect of $96 million in prior-period medical claims reserve development in 2021 versus $47 million in 2020. This favorable prior-period medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 160 basis points in 2021 versus approximately 70 basis points in 2020.

Operating costs

- The Group and Specialty segment operating cost ratio decreased 40 basis points from 25.0% in the 2020 period to 24.6% in the 2021 period primarily due to the termination of the non-deductible health insurance industry fee in 2021, lower COVID-19 related administrative costs in 2021, as previously discussed, as well as operating cost efficiencies driven by previously implemented productivity initiatives. These were partially offset by continued strategic investments made to position us for long-term success. The non-deductible health insurance industry fee impacted the operating cost ratio by 130 basis points in the 2020 period.

Healthcare Services Segment

	2021	2020	Change Dollars	Change Percentage
		(in millions)		
Revenues:				
Services:				
Home solutions	$ 1,166	$ 107	$ 1,059	989.7 %
Pharmacy solutions	637	581	56	9.6 %
Provider services	413	328	85	25.9 %
Total services revenues	2,216	1,016	1,200	118.1 %
Intersegment revenues:				
Home solutions	691	566	125	22.1 %
Pharmacy solutions	25,855	24,587	1,268	5.2 %
Provider services	2,476	2,266	210	9.3 %
Total intersegment revenues	29,022	27,419	1,603	5.8 %
Total services and intersegment revenues	$ 31,238	28,435	2,803	9.9 %
Segment earnings	$ 1,329	$ 944	$ 385	40.8 %
Operating cost ratio	95.4 %	96.3 %		(0.9)%

Segment Earnings

- Healthcare Services segment earnings increased $385 million, or 40.8%, from $944 million in the 2020 period to $1.3 billion in the 2021 period primarily due to consolidation of Kindred at Home earnings, individual Medicare Advantage and state-based contracts membership growth leading to higher pharmacy revenues, higher revenues associated with growth in the company's provider business, as well as the factors that drove the segment declining operating cost ratio as more fully described below.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 515 million in 2021, up 7.7% versus scripts of approximately 478 million in 2020 primarily due to growth in Medicare Advantage Prescription Drug and state-based contracts membership, partially offset by the decline in stand-alone PDP membership.

Services revenue

- Services revenues increased $1.2 billion, or 118.1%, from $1.0 billion in the 2020 period to $2.2 billion in the 2021 period primarily due to consolidation of Kindred at Home earnings. The 2021 period further reflects higher revenue from growth in the number of primary care clinics serving third party payors, and additional pharmacy revenues associated with the acquisition of Enclara which was closed during the first quarter of 2020.

Intersegment revenues

- Intersegment revenues increased $1.6 billion, or 5.8%, from $27.4 billion in the 2020 period to $29.0 billion in the 2021 period primarily due to individual Medicare Advantage and state-based contracts membership growth, as well as higher revenues associated with our provider business. These increases were partially offset by the loss of intersegment revenues associated with the decline in stand-alone PDP and group Medicare Advantage membership as previously discussed.

Operating costs

- The Healthcare Services segment operating cost ratio decreased 90 basis points from 96.3% in the 2020 period to 95.4% in the 2021 period primarily due to consolidation of Kindred at Home operations which have a lower operating cost ratio than other businesses within the segment, the 2020 impact associated with COVID-19 administrative related costs, including expenses associated with additional safety measures taken for our pharmacy, provider, and home solutions teams who continued to provide services to members throughout the crisis, as well as operational improvements in our provider services business, largely related to Conviva, along with operating cost efficiencies driven by previously implemented productivity initiatives in 2021. The decrease further reflects the impact of additional investments in the segment's provider business during 2020 related to marketing and AEP initiatives. These decreases were partially offset by increased administrative costs in the pharmacy operations as a result of incremental spend to accelerate growth within the business, increased utilization levels in our provider business in 2021 compared to levels in 2020 amid the COVID-19 pandemic, as well as increased pharmacy labor-related overtime costs due to weather disruptions occurring in the first quarter of 2021.

Liquidity

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

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2021 Form 10-K.

Cash and cash equivalents decreased to $3.4 billion at December 31, 2021 from $4.7 billion at December 31, 2020. The change in cash and cash equivalents for the years ended December 31, 2021, 2020 and 2019 is summarized as follows:

	2021	2020	2019
		(in millions)	
Net cash provided by operating activities	$ 2,262	$ 5,639	$ 5,284
Net cash used in investing activities	(6,556)	(3,065)	(1,278)
Net cash provided by (used in) financing activities	3,015	(1,955)	(2,295)
(Decrease) increase in cash and cash equivalents	$ (1,279)	$ 619	$ 1,711

Cash Flow from Operating Activities

Cash flows provided by operations of $2.3 billion in the 2021 period decreased $3.4 billion from cash flows provided by operations of $5.6 billion in the 2020 period primarily due to the negative impact of working capital items and lower earnings in the 2021 period compared to the 2020 period. Our 2021 period operating cash flows were significantly impacted by changes to working capital levels, primarily as a result of prior year disruptions caused by COVID-19. These impacts include paying down claims inventory and capitation for provider surplus amounts earned in 2020 as well as additional provider support.

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

The detail of benefits payable was as follows at December 31, 2021, 2020 and 2019:

	2021	2020	2019	Change 2021	Change 2020
	(in millions)				
IBNR (1)	$ 5,695	$ 5,290	$ 4,150	$ 405	$ 1,140
Reported claims in process (2)	907	816	628	91	188
Other benefits payable (3)	1,687	2,037	1,226	(350)	811
Total benefits payable	$ 8,289	$ 8,143	$ 6,004	146	2,139
Reconciliation to cash flow statement:					
Change in payables from acquisition of business				(42)	—
Changes in benefits payable per cash flow statement resulting in cash from operations				$ 104	$ 2,139

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

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

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

The increase in benefits payable in 2021 was primarily due to higher IBNR and an increase in reported claims in process partially offset by a reduction in capitation accruals. IBNR increased primarily as a result of individual Medicare Advantage membership growth partially offset by paying down claim inventories. Higher reported claims in process was a function of timing of month-end cutoff. The 2020 period was significantly impacted by higher capitation accruals as significantly lower utilization caused by COVID-19 resulted in higher surplus accruals to providers. These higher surplus accrual to providers were paid down during 2021.

The detail of total net receivables was as follows at December 31, 2021, 2020 and 2019:

	2021	2020	2019	Change 2021	Change 2020
		(in millions)			
Medicare	$ 1,214	$ 928	$ 835	$ 286	$ 93
Commercial and other	579	122	162	457	(40)
Military services	104	160	128	(56)	32
Allowance for doubtful accounts	(83)	(72)	(69)	(11)	(3)
Total net receivables	$ 1,814	$ 1,138	$ 1,056	676	82
Reconciliation to cash flow statement:					
Change in receivables from (acquisition) disposition of business				(396)	3
Change in receivables per cash flow statement resulting in cash used by operations				$ 280	$ 85

The changes in Medicare receivables for both the 2021 period and the 2020 period reflect individual Medicare Advantage membership growth and the typical pattern caused by the timing of accruals and related collections associated with the CMS risk-adjustment model. The increase in Commercial and other receivables in 2021 primarily relates to the Kindred at Home acquisition.

Cash Flow from Investing Activities

During 2021, we acquired Kindred at Home and other primary care businesses for cash consideration of approximately $4.2 billion, net of cash received.

During 2020, we acquired Enclara Healthcare, a hospice, pharmacy and benefit provider, for cash consideration of approximately $709 million, net of cash received.

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 $1.3 billion, $964 million and $736 million in the 2021, 2020 and 2019 periods, respectively.

Net purchases of investment securities were $1.1 billion, $1.4 billion, $542 million in the 2021, 2020 and 2019 periods, respectively.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Claim payments were higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk by $261 million, $938 million and $560 million in the 2021, 2020 and 2019 periods, respectively. Our net receivable from CMS for subsidies and brand name prescription drug discounts was $1.4 billion at December 31, 2021 compared to a net receivable of $1.2 billion at December 31, 2020.

Under our administrative services only TRICARE contract, health care costs payments for which we do not assume risk exceeded reimbursements from the federal government by $45 million, $1 million and $63 million in the 2021, 2020 and 2019 periods, respectively.

In August 2021, we issued $1.5 billion of 0.650% unsecured senior notes due August 3, 2023, $750 million of 1.350% unsecured senior notes due February 3, 2027 and $750 million of 2.150% unsecured senior notes due February 3, 2032. Our net proceeds, reduced for the underwriters' discounts and commissions paid, were $2,984 million.

As of the closing of the acquisition of Kindred at Home in August 2021, we assumed approximately $2.1 billion of borrowings, and subsequently repaid $150 million of borrowings. In October 2021, we entered into a $2.0 billion term loan agreement and applied the proceeds to finance the repayment in full of the outstanding assumed Kindred at Home debt.

In May 2021, we entered into a $500 million unsecured delayed draw term loan credit agreement. In August 2021, we borrowed $500 million under the delayed draw term loan agreement, which was used, in combination with other debt financing, to fund the approximate $5.8 billion transaction price of Kindred at Home.

In December 2020, we repaid $400 million aggregate principal amount of our 2.5% senior notes due on their maturity date of December 15, 2020.

In March 2020, we drew $1 billion on the existing term loan commitment at the time, which was repaid in November 2020.

In March 2020, we issued $600 million of 4.500% senior notes due April 1, 2025 and $500 million of 4.875% senior notes due April 1, 2030. Our net proceeds, reduced for the underwriters' discounts and commissions and offering expenses paid, were $1,088 million.

In August 2019, we issued $500 million of 3.125% senior notes due August 15, 2029 and $500 million of 3.950% senior notes due August 15, 2049. Our net proceeds, reduced for the underwriters' discounts and commissions and offering expenses paid, were $987 million. We used the net proceeds from this offering, together with available cash, to repay the $650 million outstanding amount due under our term note in August 2019, and the $400 million aggregate principal amount of our 2.625% senior notes due on its maturity date of October 1, 2019.

We repurchased common shares for $0.08 billion, $1.82 billion and $1.07 billion in 2021, 2020 and 2019, respectively, under share repurchase plans authorized by the Board of Directors and in connection with employee stock plans.

We paid dividends to stockholders of $354 million in 2021, $323 million in 2020, and $291 million in 2019.

We entered into a commercial paper program in October 2014. Net proceeds from issuance of commercial paper were $352 million in 2021 and the maximum principal amount outstanding at any one time during 2021 was $1.2 billion. Net proceeds from the issuance of commercial paper were $295 million in 2020 and the maximum principal amount outstanding at any one time during 2020 was $600 million. Net repayments from issuance of commercial paper were $360 million in 2019 and the maximum principal amount outstanding at any one time during 2019 was $801 million.

The remainder of the cash used in or provided by financing activities in 2021, 2020, and 2019 primarily resulted from debt issuance costs, proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

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

Stock Repurchases

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

Debt

For a detailed discussion of our debt, including our senior notes, term loans, credit agreement and commercial paper program, please refer to Note 13 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

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, 2021 was BBB+ according to Standard & Poor’s Rating Services, or S&P, and Baa3 according to Moody’s Investors Services, Inc., or Moody’s. A downgrade by S&P to BB+ or by Moody’s to Ba1 triggers an interest rate increase of 25 basis points with respect to $250 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $1 million, up to a maximum 100 basis points, or annual interest expense by $3 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company increased to $1.3 billion at December 31, 2021 from $772 million at December 31, 2020. This increase primarily reflects net proceeds from the senior notes and term loans, dividends received from regulated subsidiaries, earnings in non-regulated Healthcare Services subsidiaries, and the issuance of commercial paper, partially offset by acquisitions, capital contributions to certain subsidiaries, capital expenditures, and cash dividends to shareholders. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by regulators. Our regulated insurance subsidiaries paid dividends to our parent company of $1.6 billion in 2021, $1.3 billion in 2020, and $1.8 billion in 2019. Subsidiary capital requirements from significant premium growth has impacted the amount of regulated subsidiary dividends over the last two years. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. The amount of ordinary dividends that may be paid to our parent company in 2022 is approximately $1.5 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to our parent, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Off-Balance Sheet Arrangements

As of December 31, 2021, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid and state-based contracts, please refer to Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Critical Accounting Policies and Estimates

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

Benefits Expense Recognition

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

	December 31, 2021	Percentage of Total	December 31, 2020	Percentage of Total
	(dollars in millions)			
IBNR	$ 5,695	68.7 %	$ 5,290	65.0 %
Reported claims in process	907	10.9 %	816	10.0 %
Other benefits payable	1,687	20.4 %	2,037	25.0 %
Total benefits payable	$ 8,289	100.0 %	$ 8,143	100.0 %

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

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderately adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2021 data:

Completion Factor (a):		**Claims Trend Factor (b):**	
Factor Change (c)	**Decrease in Benefits Payable**	**Factor Change (c)**	**Decrease in Benefits Payable**
	(dollars in millions)		
0.70%	$(421)	3.00%	$(379)
0.60%	$(361)	2.75%	$(347)
0.50%	$(301)	2.50%	$(316)
0.40%	$(241)	2.25%	$(284)
0.30%	$(180)	2.00%	$(252)
0.20%	$(120)	1.75%	$(221)
0.10%	$(60)	1.50%	$(189)

(a) Reflects estimated potential changes in benefits payable at December 31, 2021 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2021 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

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

The following table provides a historical perspective regarding the accrual and payment of our benefits payable. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail and Group and Specialty segment tables including information about incurred and paid claims development as of December 31, 2021, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2021	2020	2019
		(in millions)	
Balances at January 1	$ 8,143	$ 6,004	$ 4,862
Less: Reinsurance recoverables	—	(68)	(95)
Balances at January 1, net	8,143	5,936	4,767
Acquisitions	42	—	—
Incurred related to:			
Current year	70,024	61,941	54,193
Prior years	(825)	(313)	(336)
Total incurred	69,199	61,628	53,857
Paid related to:			
Current year	(62,149)	(54,003)	(48,421)
Prior years	(6,946)	(5,418)	(4,267)
Total paid	(69,095)	(59,421)	(52,688)
Reinsurance recoverable	—	—	68
Balances at December 31	$ 8,289	$ 8,143	$ 6,004

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					
	2021		2020		2019	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
			(dollars in millions)			
Trend factors	$ (361)	(3.3)%	$ (167)	(1.9)%	$ (233)	(3.1)%
Completion factors	(464)	(0.9)%	(146)	(0.3)%	(103)	(0.3)%
Total	$ (825)		$ (313)		$ (336)	

(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 $825 million in 2021, $313 million in 2020, and $336 million in 2019. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2021, 2020, and 2019.

	(Favorable) Unfavorable Medical Claims Reserve Development			Change	
	2021	2020	2019	2021	2020
			(in millions)		
Retail Segment	$ (729)	$ (266)	$ (386)	$ (463)	$ 120
Group and Specialty Segment	(96)	(47)	50	(49)	(97)
Total	$ (825)	$ (313)	$ (336)	$ (512)	$ 23

The favorable medical claims reserve development for 2021, 2020, and 2019 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. In addition, the higher prior year favorable development for the year ended December 31, 2021 was primarily attributable to the reversal of actions taken in 2020, including the suspension of certain financial recovery programs for a period of time impacting our claim payment patterns. The suspension during 2020 was intended to provide financial and administrative relief for providers facing unprecedented strain as a result of the COVID-19 pandemic. Our favorable development for each of the years presented above is discussed further in Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2021 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Revenue Recognition

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

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premiums from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and recognized ratably during the year with adjustments each period to reflect changes in the ultimate premium.

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

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2021, 75% of the risk score was calculated from claims data submitted through EDS. CMS will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled “Individual Medicare,” and in Item 1A. - Risk Factors.

Investment Securities

Investment securities totaled $14.0 billion, or 31% of total assets at December 31, 2021, and $13.8 billion, or 39% of total assets at December 31, 2020. The investment portfolio was primarily comprised of debt securities, detailed below, at December 31, 2021 and December 31, 2020. The fair value of investment securities were as follows at December 31, 2021 and 2020:

	12/31/2021	Percentage of Total	12/31/2020	Percentage of Total
		(dollars in millions)		
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 602	4.3 %	$ 616	4.5 %
Mortgage-backed securities	3,229	23.1 %	3,254	23.6 %
Tax-exempt municipal securities	841	6.0 %	1,447	10.5 %
Mortgage-backed securities:				
Residential	367	2.6 %	17	0.1 %
Commercial	1,410	10.1 %	1,318	9.6 %
Asset-backed securities	1,348	9.7 %	1,372	10.0 %
Corporate debt securities	5,700	40.8 %	4,927	35.8 %
Total debt securities	13,497	96.6 %	12,951	94.1 %
Common stock	475	3.4 %	815	5.9 %
Total investment securities	$ 13,972	100.0 %	$ 13,766	100.0 %

Approximately 95% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2021. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 1% of our total debt securities. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2021:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 201	$ (3)	$ 355	$ (7)	$ 556	$ (10)
Mortgage-backed securities	2,082	(49)	556	(20)	2,638	(69)
Tax-exempt municipal securities	68	(1)	34	(1)	102	(2)
Mortgage-backed securities:						
Residential	358	(6)	8	—	366	(6)
Commercial	295	(4)	400	(7)	695	(11)
Asset-backed securities	530	(3)	425	(1)	955	(4)
Corporate debt securities	1,456	(28)	769	(31)	2,225	(59)
Total debt securities	$ 4,990	$ (94)	$ 2,547	$ (67)	$ 7,537	$ (161)

Prior to January 1, 2020, we applied the other-than-temporary impairment model for securities in an unrealized loss position which did not result in any material impairments for 2019. Beginning on January 1, 2020, we adopted the new current expected credit losses, or CECL, model which retained many similarities from the previous other-than-temporary impairment model except eliminating from consideration in the impairment analysis the length of time over which the fair value had been less than cost. Also, under the CECL model, expected losses on available for sale debt securities are recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities. For debt securities whose fair value is less than their amortized cost which we do not intend to sell or are not required to sell, we evaluate the expected cash flows to be received as compared to amortized cost and determine if an expected credit loss has occurred. In the event of an expected credit loss, only the amount of the impairment associated with the expected credit loss is recognized in income with the remainder, if any, of the loss recognized in other comprehensive income. To the extent we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value.

Potential expected credit loss impairment is considered using a variety of factors, including the extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a debt security; changes in the quality of the debt security's credit enhancement; payment structure of the debt security; changes in credit rating of the debt security by the rating agencies; failure of the issuer to make scheduled principal or interest payments on the debt security and changes in prepayment speeds. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. We estimate the amount of the expected credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The expected credit loss cannot exceed the full difference between the amortized cost basis and the fair value.

The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an investment is related to a credit event requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or expected credit loss impairments may be recorded in future periods.

All issuers of debt securities we own that were trading at an unrealized loss at December 31, 2021 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2021, we did not intend to sell any debt securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these debt securities before recovery of their amortized cost basis. Additionally, we did not record any material credit allowances for debt securities that were in an unrealized loss position at December 31, 2021 or 2020 There were no material other-than-temporary impairments in 2019.

Goodwill, Indefinite-lived and Long-lived Assets

At December 31, 2021, goodwill, indefinite-lived and other long-lived assets represented 38% of total assets and 104% of total stockholders' equity, compared to 20% and 52%, respectively, at December 31, 2020. The increase in goodwill, indefinite-lived and other long-lived assets is primarily attributable to our August 2021 KAH acquisition.

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

We perform a quantitative assessment to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in government reimbursement rates, the estimates underlying our goodwill impairment tests could be adversely affected. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. However, unfavorable changes in key assumptions or combinations of assumptions including a significant increase in the discount rate, decrease in the long-term growth rate or substantial reduction in our underlying cash flow assumptions, including revenue growth rates, medical and operating cost trends, and projected operating income could have a significant negative impact on the estimated fair value of our home solutions and provider reporting units, which accounted for $6.6 billion and $933 million of goodwill, respectively. Our home solutions reporting unit includes approximately $5.8 billion of goodwill from our August 2021 KAH acquisition. Impairment tests completed for 2021, 2020, and 2019 did not result in an impairment loss.

Indefinite-lived intangible assets relate to Certificate of Needs (CON) and Medicare licenses acquired in connection with our August 2021 KAH acquisition with a carrying value of $2.3 billion at December 31, 2021. Like goodwill, we are required to test at least annually for impairment and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. These tests are performed, at a minimum, annually in the fourth quarter. If the carrying amount of an indefinite-lived intangible asset exceeds its fair value, an impairment loss is recognized. Fair values of indefinite-lived intangible assets are determined based on the income approach. Impairment tests completed for 2021 did not result in an impairment loss.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. In the past we have, and in the future we may enter into interest rate swap agreements depending on market conditions and other factors. Under the revolving credit agreements, 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 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 revolving credit agreements provide for the transition from LIBOR and do not require amendment in connection with such transition. There were no borrowings outstanding under our credit agreements at December 31, 2021 or December 31, 2020.

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, 2021. Our net unrealized position decreased $457 million from a net unrealized gain position of $514 million at December 31, 2020 to a net unrealized gain position of $57 million at December 31, 2021. At December 31, 2021, we had gross unrealized losses of $161 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. We did not record any material credit allowances for debt securities that were in an unrealized loss position during 2021 and 2020. While we believe that these impairments will be recovered and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or credit loss impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio’s cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 3.6 years as of December 31, 2021 and 3.0 years. as of December 31, 2020. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the December 31, 2021 fair value of our securities by approximately $606 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, 2021 and 2020. 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, spread changes specific to various investment categories and the mix of short-term versus long-term debt. In the past ten years, changes in 10 year US treasury rates during the year have not exceeded 300 basis points, have changed between 200 and 300 basis points 0, have changed between 100 and 200 basis points 4, and have changed by less than 100 basis points 6.

	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, 2021						
Investment income (a)	$ (46)	$ (29)	$ (15)	$ 71	$ 142	$ 213
Interest expense (b)	7	7	7	(35)	(70)	(105)
Pretax	$ (39)	$ (22)	$ (8)	$ 36	$ 72	$ 108
As of December 31, 2020						
Investment income (a)	$ (44)	$ (33)	$ (21)	$ 91	$ 180	$ 270
Interest expense (b)	2	2	2	(6)	(12)	(18)
Pretax	$ (42)	$ (31)	$ (19)	$ 85	$ 168	$ 252

(a) As of December 31, 2021 and 2020, some of our investments had interest rates below 1% and 2%, respectively, so the assumed hypothetical change in pretax earnings does not reflect the full 1% and 2%, respectively, point reduction.

(b) The interest rate under our senior notes, which represent 72% of total debt, is fixed, unaffected by changes in interest rates. We had $2.5 billion of variable rate term loans at December 31, 2021, used to fund the August 2021 KAH acquisition. There were no term loans at December 31, 2020. There were no borrowings outstanding under the credit agreement at December 31, 2021 or December 31, 2020. There was $955 million and $600 million outstanding under our commercial paper program at December 31, 2021 and 2020, respectively. As of December 31, 2021 and 2020, our interest rate under our commercial paper program was less than 1% so the assumed hypothetical change in pretax earnings does not reflect the full 1% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.

CONSOLIDATED BALANCE SHEETS

	December 31, 2021	December 31, 2020
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,394	$ 4,673
Investment securities	13,192	12,554
Receivables, less allowance for doubtful accounts of $83 in 2021 and $72 in 2020	1,814	1,138
Other current assets	6,493	5,276
Total current assets	24,893	23,641
Property and equipment, net	3,073	2,371
Long-term investment securities	780	1,212
Goodwill	11,092	4,447
Equity method investments	141	1,170
Other long-term assets	4,379	2,128
Total assets	$ 44,358	$ 34,969
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 8,289	$ 8,143
Trade accounts payable and accrued expenses	4,509	4,013
Book overdraft	326	320
Unearned revenues	254	318
Short-term debt	1,953	600
Total current liabilities	15,331	13,394
Long-term debt	10,541	6,060
Other long-term liabilities	2,383	1,787
Total liabilities	28,255	21,241
Commitments and contingencies (Note 17)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,648,742 shares issued at December 31, 2021 and December 31, 2020	33	33
Capital in excess of par value	3,082	2,705
Retained earnings	23,086	20,517
Accumulated other comprehensive income	42	391
Treasury stock, at cost, 69,846,758 shares at December 31, 2021 and 69,787,914 shares at December 31, 2020	(10,163)	(9,918)
Noncontrolling interests	23	—
Total stockholders' equity	16,103	13,728
Total liabilities and stockholders' equity	$ 44,358	$ 34,969

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

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2021	2020	2019
	(in millions, except per share results)		
Revenues:			
Premiums	$ 79,822	$ 74,186	$ 62,948
Services	3,055	1,815	1,439
Investment income	187	1,154	501
Total revenues	83,064	77,155	64,888
Operating expenses:			
Benefits	69,199	61,628	53,857
Operating costs	10,121	10,052	7,381
Depreciation and amortization	596	489	458
Total operating expenses	79,916	72,169	61,696
Income from operations	3,148	4,986	3,192
Interest expense	326	283	242
Other (income) expense, net	(532)	103	(506)
Income before income taxes and equity in net earnings	3,354	4,600	3,456
Provision for income taxes	485	1,307	763
Equity in net earnings	65	74	14
Net income	$ 2,934	$ 3,367	$ 2,707
Less: Net income attributable to noncontrolling interests	(1)	—	—
Net income attributable to Humana	$ 2,933	$ 3,367	$ 2,707
Basic earnings per common share	$ 22.79	$ 25.47	$ 20.20
Diluted earnings per common share	$ 22.67	$ 25.31	$ 20.10

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

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2021	2020	2019
	(in millions)		
Net income attributable to Humana	$ 2,933	$ 3,367	$ 2,707
Other comprehensive income (loss):			
Change in gross unrealized investment (losses) gains	(356)	393	450
Effect of income taxes	81	(89)	(105)
Total change in unrealized investment (losses) gains, net of tax	(275)	304	345
Reclassification adjustment for net realized gains included in investment income	(103)	(90)	(34)
Effect of income taxes	23	20	8
Total reclassification adjustment, net of tax	(80)	(70)	(26)
Other comprehensive (loss) income, net of tax	(355)	234	319
Comprehensive income (loss) attributable to equity method investments	6	1	(4)
Comprehensive income	$ 2,584	$ 3,602	$ 3,022

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

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock							
	Issued Shares	Amount	Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Noncontrolling Interests	Total Stockholders' Equity
	(dollars in millions, share amounts in thousands)							
Balances, January 1, 2019	198,595	$ 33	$ 2,535	$ 15,072	$ (159)	$ (7,320)	—	$ 10,161
Net income				2,707				2,707
Other comprehensive income				—	315			315
Common stock repurchases	—		150			(1,220)		(1,070)
Dividends and dividend equivalents			—	(296)				(296)
Stock-based compensation			163					163
Restricted stock unit vesting	32	—	(48)			48		—
Stock option exercises	3	—	20			37		57
Balances, December 31, 2019	198,630	33	2,820	17,483	156	(8,455)	—	12,037
Net income				3,367				3,367
Impact of adopting accounting standard				(2)				(2)
Other comprehensive income				—	235			235
Common stock repurchases	—		(263)			(1,557)		(1,820)
Dividends and dividend equivalents			—	(331)				(331)
Stock-based compensation			181					181
Restricted stock unit vesting	19	—	(59)			59		—
Stock option exercises	—	—	26			35		61
Balances, December 31, 2020	198,649	33	2,705	20,517	391	(9,918)	—	13,728
Net income				2,933			1	2,934
Acquisition							22	22
Other comprehensive loss				—	(349)			(349)
Common stock repurchases			262			(341)		(79)
Dividends and dividend equivalents			—	(364)				(364)
Stock-based compensation			180					180
Restricted stock unit vesting			(81)			81		—
Stock option exercises			16			15		31
Balances, December 31, 2021	198,649	$ 33	$ 3,082	$ 23,086	$ 42	$ (10,163)	$ 23	$ 16,103

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

Humana Inc.

CONSOLIDATED STATEMENTS OF CASH FLOW

	For the year ended December 31,		
	2021	2020	2019
	(in millions)		
Cash flows from operating activities			
Net income	$ 2,934	$ 3,367	$ 2,707
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss (gain) on investment securities, net	130	(838)	(62)
Gain on Kindred at Home equity method investment	(1,129)	—	—
Equity in net earnings	(65)	(74)	(14)
Stock compensation	180	181	163
Depreciation	640	528	505
Amortization	73	88	70
Provision for deferred income taxes	15	195	162
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(280)	(85)	(32)
Other assets	(491)	(581)	118
Benefits payable	104	2,139	1,142
Other liabilities	176	599	471
Unearned revenues	(65)	71	(36)
Other	40	49	90
Net cash provided by operating activities	2,262	5,639	5,284
Cash flows from investing activities			
Acquisitions, net of cash and cash equivalents acquired	(4,187)	(709)	—
Purchases of property and equipment, net	(1,316)	(964)	(736)
Purchases of investment securities	(7,197)	(9,125)	(6,361)
Proceeds from maturities of investment securities	2,597	4,986	1,733
Proceeds from sales of investment securities	3,547	2,747	4,086
Net cash used in investing activities	(6,556)	(3,065)	(1,278)
Cash flows from financing activities			
Withdrawals receipts from contract deposits, net	(306)	(939)	(623)
Proceeds from issuance of senior notes, net	2,984	1,088	987
Repayment of senior notes	—	(400)	(400)
Proceeds (repayments) from issuance of commercial paper, net	352	295	(360)
Proceeds from term loan	2,500	1,000	—
Repayment of term loan	(2,078)	(1,000)	(650)
Debt issue costs	(31)	—	—
Common stock repurchases	(79)	(1,820)	(1,070)
Dividends paid	(354)	(323)	(291)
Change in book overdraft	6	95	54
Proceeds from stock option exercises & other	21	49	58
Net cash provided by (used in) financing activities	3,015	(1,955)	(2,295)
(Decrease) increase in cash and cash equivalents	(1,279)	619	1,711
Cash and cash equivalents at beginning of period	4,673	4,054	2,343
Cash and cash equivalents at end of period	$ 3,394	$ 4,673	$ 4,054

Humana Inc.

CONSOLIDATED STATEMENTS OF CASH FLOW—(Continued)

	For the year ended December 31,		
	2021	2020	2019
Supplemental cash flow disclosures:	(in millions)		
Interest payments	$ 285	$ 258	$ 212
Income tax payments, net	$ 227	$ 1,132	$ 518
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 9,804	$ 819	$ 28
Less: Fair value of liabilities assumed	(3,235)	(110)	(28)
Less: Noncontrolling interests acquired	(22)	—	—
Less: Remeasured existing Kindred at Home equity method investment	(2,360)	—	—
Cash paid for acquired businesses, net of cash acquired	$ 4,187	$ 709	$ —

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

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective. References throughout these notes to consolidated financial statements to “we,” “us,” “our,” “Company,” and “Humana,” mean Humana Inc. and its subsidiaries. We derived approximately 83% of our total premiums and services revenue from contracts with the federal government in 2021, including 15% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government’s agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

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

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

COVID-19

The emergence and spread of the novel coronavirus, or COVID-19, beginning in the first quarter of 2020 has impacted our business. During periods of increased incidences of COVID-19, non-essential care from a reduction in non-COVID-19 hospital admissions and lower overall healthcare system consumption decreased utilization. At the same time, COVID-19 treatment and testing costs increased utilization. The significant disruption in utilization during 2020 also impacted our ability to implement clinical initiatives to manage health care costs and chronic conditions of our members, and appropriately document their risk profiles, and, as such, significantly affected our 2021 revenue under the risk adjustment payment model for Medicare Advantage plans. Finally, changes in utilization patterns and actions taken in 2020 and 2021 as a result of the COVID-19 pandemic, including the suspension of certain financial recovery programs for a period of time and shifting the timing of claim payments and provider capitation surplus payments, impacted our claim reserve development and operating cash flows for 2020 and 2021.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurance industry fee, but the fee resumed in calendar year 2020. The Further Consolidated Appropriations Act, 2020, enacted on December 20, 2019, permanently repealed the health insurance industry fee beginning in calendar year 2021.

The annual premium-based fee on health insurers were not deductible for tax purposes. We estimated a liability for the health insurance industry fee and recorded it in full once qualifying insurance coverage was provided in the applicable calendar year in which the fee was payable with a corresponding deferred cost that was amortized ratably to expense over the same calendar year. We recorded the liability for the health insurance industry fee in trade accounts payable and accrued expenses and recorded the deferred cost in other current assets in our consolidated financial statements. We paid the health insurance industry fee in September or October of each year. We paid the federal government $1.18 billion for the annual health insurance industry fee attributed to calendar year 2020.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under Health Care Reform, for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, we received a $609 million payment from the U.S Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $609 million payment received from the U.S Government and approximately $31 million in related fees and expenses are reflected in Premiums revenue and Operating costs, respectively, in our consolidated statements of income for the year ended December 31, 2020 and reported in the Corporate segment.

Cash and Cash Equivalents

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

Investment Securities

Investment securities, which consist of debt and equity securities, are stated at fair value. Our debt securities have been categorized as available for sale. Debt securities available for current operations are classified as current assets and debt securities available to fund our professional and other self-insurance liability requirements, as well as restricted statutory deposits and equity securities, are classified as long-term assets. For the purpose of determining realized gross gains and losses for debt securities sold, which are included as a component of investment income in the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses for debt securities, net of applicable deferred taxes, are included as a component of stockholders’ equity and comprehensive income until realized from a sale or an expected credit loss is recognized. For the purpose of determining gross gains and losses for equity securities, changes in fair value at the reporting date are included as a component of investment income in the consolidated statements of income.

Prior to January 1, 2020, we applied the other-than-temporary impairment model for securities in an unrealized loss position which did not result in any material impairments for 2019. Beginning on January 1, 2020, we adopted the new current expected credit losses, or CECL, model which retained many similarities from the previous other-than-temporary impairment model except eliminating from consideration in the impairment analysis the length of time over which the fair value had been less than cost. Also, under the CECL model, expected losses on available for sale debt securities are recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities. For debt securities whose fair value is less than their amortized cost which we do not intend to sell or are not required to sell, we evaluate the expected cash flows to be received as compared to amortized cost and determine if an expected credit loss has occurred. In the event of an expected credit loss, only the amount of the impairment associated with the expected credit loss is recognized in income with the remainder, if any, of the loss recognized in other comprehensive income. To the extent we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value.

Potential expected credit loss impairment is considered using a variety of factors, including the extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a debt security; changes in the quality of the debt security's credit enhancement; payment structure of the debt security; changes in credit rating of the debt security by the rating agencies; failure of the issuer to make scheduled principal or interest payments on the debt security and changes in prepayment speeds. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. We estimate the amount of the expected credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The expected credit loss cannot exceed the full difference between the amortized cost basis and the fair value.

Receivables and Revenue Recognition

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

Premiums Revenue

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium. Receivables or payables are classified as current or long-term in our consolidated balance sheet based on the timing of the expected settlement.

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

Medicare Part D

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

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

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows.

	2021	2020	2019
		(in millions)	
Part D subsidy/discount payments	$ (14,889)	$ (13,348)	$ (11,762)
Part D subsidy/discount reimbursements	14,628	12,410	11,202
Net payments	$ (261)	$ (938)	$ (560)

We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 7 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

Patient services include services related to pharmacy solutions, provider services, and home solutions services, such as home health and other services and capabilities to promote wellness and advance population health. Patient services revenues are reported in the amount reflecting the ultimate consideration we expect to receive, primarily from government programs (Medicare and Medicaid), net of contractual allowances, discounts, or other implicit price concessions. We estimate the transaction price utilizing contractual rates, historical experience and current conditions. Patient services revenues are recognized as performance obligations are satisfied, which is in the period services are rendered.

For the year ended December 31, 2021, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price), was not material. Further, revenue expected to be recognized in any future year related to remaining performance obligations was not material.

Administrative services fees

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

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

Our TRICARE members are served by both in-network and out-of-network providers in accordance with our contracts. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows.

	2021	2020	2019
		(in millions)	
Health care cost payments	$ (6,943)	$ (6,253)	$ (6,475)
Health care cost reimbursements	6,898	6,252	6,412
Net payments	$ (45)	$ (1)	$ (63)

Receivables

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

At December 31, 2021 and 2020, accounts receivable related to services were $475 million and $161 million, respectively. For the years ended December 31, 2021, 2020 and 2019, we had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the consolidated balance sheet at December 31, 2021 and 2020.

Other Current Assets

Other current assets include amounts associated with Medicare Part D as discussed above and in Note 7, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates receivable was $2.0 billion and $1.4 billion at December 31, 2021 and 2020, respectively.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be canceled upon 30 days notice by the employer group.

Long-Lived Assets

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

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

Equity Method Investments

We use the equity method of accounting for equity investments in companies where we are able to exercise significant influence, but not control, over operating and financial policies of the investee. Judgment regarding the level of influence over each equity method investment includes considering key factors such as our ownership interest, representation on the board of directors, organizational structure, participation in policy-making decisions and material intra-entity transactions.

Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by our share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies. Our proportionate share of the net income or loss of these companies is included in consolidated net income. Investment amounts in excess of our share of an investee's net assets are amortized over the life of the related asset creating the excess. Excess goodwill is not amortized.

We evaluate equity method investments for impairment whenever events or changes in circumstances indicate that the carrying amount of the investment might not be recoverable. Factors considered by us when reviewing an equity method investment for impairment include the length of time (duration) and the extent (severity) to which the fair value of the equity method investment has been less than carrying value, the investee's financial condition and near-term prospects and the intent and ability to hold the investment for a period of time sufficient to allow for anticipated recovery. An impairment that is other-than-temporary is recognized in the period identified.

Additional detail regarding our equity method investments is included in Note 4.

Goodwill and Intangible Assets

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

We perform a quantitative assessment to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. However, unfavorable changes in key assumptions or combinations of assumptions including a significant increase in the discount rate, decrease in the long-term growth rate or substantial reduction in our underlying cash flow assumptions, including revenue growth rates, medical and operating cost trends, and projected operating income could have a significant negative impact on the estimated fair value of our home solutions and provider reporting units, which accounted for $6.6 billion and $0.9 billion of goodwill, respectively. Impairment tests completed for 2021, 2020, and 2019 did not result in an impairment loss.

Indefinite-lived intangible assets relate to Certificate of Needs (CON) and Medicare licenses acquired as part of our acquisition of Kindred at Home, or KAH, and are included within other long-term assets in the consolidated balance sheet at December 31, 2021. See Note 3 for further information. We are required to annually compare the fair values of other indefinite-lived intangible assets to their carrying amounts. If the carrying amount of an indefinite-lived intangible asset exceeds its fair value, an impairment loss is recognized. Fair values of indefinite-lived intangible assets are determined based on the income approach. Impairment tests completed for 2021 did not result in an impairment loss.

Definite-lived intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Definite-lived intangible assets are amortized over the useful life generally using the straight-line method. We review definite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in other current assets in our consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health products.

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

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

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent two months, a completion factor method uses historical paid claims patterns to estimate the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. Changes in claim inventory levels and known changes in claim payment processes are taken into account in these estimates. For the most recent two months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of hospital admissions, recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and workday seasonality.

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

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, public health emergencies, epidemics and pandemics (such as the spread of COVID-19) also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent two months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent two months. Each of these factors requires significant judgment by management.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise.

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

Future policy benefits payable

Future policy benefits payable includes liabilities for long-duration insurance policies primarily related to certain blocks of insurance assumed in acquisitions, primarily life and annuities in run-off status, and are included in our consolidated balance sheet within other long-term liabilities. Most of these policies are subject to reinsurance as detailed in Note 19.

Book Overdraft

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

Income Taxes

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

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

Noncontrolling Interests

The consolidated financial statements include all assets, liabilities, revenues and expenses of less than 100% owned affiliates that we control. Accordingly, we record noncontrolling interests in the earnings and equity of such entities. We record adjustments to noncontrolling interests for the allocable portion of income or loss to which the noncontrolling interest holders are entitled based upon their portion of the subsidiaries they own. Distributions to holders of noncontrolling interests are adjusted to the respective noncontrolling interest holders' balances. Noncontrolling interests, which relate to the minority ownership held by third party investors in certain of our Home Solutions business, are reported below net income under the heading "Net income attributable to noncontrolling interests" in the consolidated statements of income and presented as a component of equity in the consolidated balance sheets.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model.

Additional detail regarding our stock-based compensation plans is included in Note 14.

Earnings Per Common Share

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

Additional detail regarding earnings per common share is included in Note 15.

Fair Value

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

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

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

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

Fair value of actively traded debt and equity securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. Fair value of privately held investment grade debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held investment grade 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 with similar credit characteristics, and reviewing the underlying financial performance including estimating discounted cash flows.

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

Recently Issued Accounting Pronouncements

Accounting Pronouncements Effective in Future Periods

In September 2018, the FASB issued new guidance related to accounting for long-duration contracts of insurers which revises key elements of the measurement models and disclosure requirements for long-duration contracts issued by insurers, including the amortization of deferred contract acquisition costs and the measurement of liabilities for future policy benefits using current, rather than locked-in, assumptions. The new guidance, limited to our Medicare supplement product which represent less than 1% of consolidated premiums and services revenue, is effective for us beginning with annual and interim periods in 2023 and is to be applied to contracts in force at the beginning of the earliest period presented, with an option to apply retrospectively with a cumulative effect adjustment to the opening balances of retained earnings as of the earliest period presented. We are currently evaluating the impact on our results of operations, financial position and cash flows.

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

3. ACQUISITIONS

On August 17, 2021, we acquired the remaining 60% interest in Kindred at Home, the nation’s largest home health and hospice provider, from TPG Capital and Welsh, Carson, Anderson & Stowe, two private equity funds, for an enterprise value of $8.2 billion, which includes our equity value of $2.4 billion associated with our 40% minority ownership interest. The remeasurement to fair value of our previously held 40% equity method investment with a carrying value of approximately $1.3 billion, resulted in a $1.1 billion gain recognized in "Other (income) expense, net". We paid the approximate $5.8 billion transaction price (net of our existing equity stake) through a combination of debt financing, the assumption of existing KAH indebtedness and parent company cash. The preliminary fair values of KAH’s assets acquired and liabilities assumed at the date of the acquisition are summarized as follows:

	Kindred at Home (in millions)
Cash and cash equivalents	$ 278
Receivables	381
Other current assets	61
Property and equipment	74
Goodwill	5,771
Other intangible assets	2,312
Other long-term assets	172
Total assets acquired	$ 9,049
Current liabilities	$ 410
Long term debt	2,078
Other long-term liabilities	369
Total liabilities assumed	$ 2,857
Noncontrolling interests	22
Net assets acquired	$ 6,170

The other intangible assets primarily consist of Certificate of Needs (CON) and Medicare licenses which have indefinite lives. Amortizing trade names included in other intangibles assets of approximately $18 million have an estimated weighted average useful life of 10 years. The goodwill, allocated to our Healthcare Services segment, primarily relates to the future economic benefit arising from the assets acquired and is consistent with our integrated care delivery strategy. Approximately $132 million of the goodwill is deductible for tax purposes. The purchase price allocation is preliminary, subject to receipt and validation of certain tax related analyses. The results of operations and financial condition of KAH have been included in our consolidated statements of income and consolidated balance sheets from the acquisition date. In connection with the acquisition, we recognized approximately $45 million of acquisition-related costs, primarily compensation costs as well as banker and other professional fees, in operating costs in our consolidated statements of income.

In the first quarter of 2020, we acquired privately held Enclara Healthcare, or Enclara, one of the nation’s largest hospice pharmacy and benefit management providers for cash consideration of approximately $709 million, net of cash received. This resulted in a purchase price allocation to goodwill of $517 million, other intangible assets of $240 million, and net tangible liabilities assumed of $13 million. The goodwill was assigned to the Healthcare Services segment. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 11 years. Enclara's goodwill is not deductible for tax purposes.

During 2021 and 2020, we acquired other health and wellness related businesses which other than the impacts to goodwill, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our consolidated statements of income and consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2021, 2020 and 2019 were not material to our results of operations. For asset acquisitions the goodwill acquired is partially amortizable as deductible expenses for tax purposes. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

4. EQUITY METHOD INVESTMENT

Prior to our acquisition of KAH in August 2021, we accounted for our 40% investment in KAH using the equity method of accounting. This investment was reflected in "Equity method investments" in our December 31, 2020 consolidated balance sheet, with our share of income or loss reported as Equity in net earnings in our consolidated statements of income.

The summarized balance sheet at December 31, 2020 and statements of income at December 31, 2020 and 2019 of KAH were as follows:

Balance sheet	**December 31, 2020**
	(in millions)
Current assets	$ 844
Non-current assets	4,858
Current liabilities	556
Non-current liabilities	2,445
Shareholders' equity	2,700

Statements of income	**For the year ended December 31, 2020**	**For the year ended December 31, 2019**
	(in millions)	
Revenues	$ 2,972	$ 3,100
Expenses	2,552	2,835
Net income	207	54

Other insignificant equity method investments

In the first quarter of 2020, our Primary Care Organization entered into a strategic partnership with Welsh, Carson, Anderson & Stowe, or WCAS, to accelerate the expansion of our primary care model. As of December 31, 2021, there were 31 primary care clinics operating under the partnership and we intend to open an additional 36 in future periods under the existing arrangement. In addition, the agreement includes a series of put and call options through which WCAS may require us to purchase their interest in the entity and, through which we may acquire WCAS's interest over the next 4 to 9 years.

We have several individually immaterial equity method investments, including our PIPC strategic partnership with WCAS as described above, included within Equity method investments in our consolidated balance sheets as of December 31, 2021, with our share of income or loss reported as Equity in net earnings in our consolidated statements of income for the years ended December 31, 2021 and 2020.

5. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2021 and 2020, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2021				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 611	$ 1	$ (10)	$ 602
Mortgage-backed securities	3,265	33	(69)	3,229
Tax-exempt municipal securities	810	33	(2)	841
Mortgage-backed securities:				
Residential	373	—	(6)	367
Commercial	1,394	27	(11)	1,410
Asset-backed securities	1,346	6	(4)	1,348
Corporate debt securities	5,641	118	(59)	5,700
Total debt securities	$ 13,440	$ 218	$ (161)	13,497
Common stock				475
Total investment securities				$ 13,972
December 31, 2020				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 616	$ 1	$ (1)	$ 616
Mortgage-backed securities	3,115	140	(1)	3,254
Tax-exempt municipal securities	1,393	54	—	1,447
Mortgage-backed securities:				
Residential	17	—	—	17
Commercial	1,260	59	(1)	1,318
Asset-backed securities	1,364	10	(2)	1,372
Corporate debt securities	4,672	256	(1)	4,927
Total debt securities	$ 12,437	$ 520	$ (6)	12,951
Common stock				815
Total investment securities				$ 13,766

Gross unrealized losses and fair values aggregated by investment category and length of time that individual debt securities have been in a continuous unrealized loss position were as follows at December 31, 2021 and 2020, 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, 2021						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 201	$ (3)	$ 355	$ (7)	$ 556	$ (10)
Mortgage-backed securities	2,082	(49)	556	(20)	2,638	(69)
Tax-exempt municipal securities	68	(1)	34	(1)	102	(2)
Mortgage-backed securities:						
Residential	358	(6)	8	—	366	(6)
Commercial	295	(4)	400	(7)	695	(11)
Asset-backed securities	530	(3)	425	(1)	955	(4)
Corporate debt securities	1,456	(28)	769	(31)	2,225	(59)
Total debt securities	$ 4,990	$ (94)	$ 2,547	$ (67)	$ 7,537	$ (161)
December 31, 2020						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 225	$ (1)	$ —	$ —	$ 225	$ (1)
Mortgage-backed securities	199	(1)	—	—	199	(1)
Tax-exempt municipal securities	16	—	19	—	35	—
Mortgage-backed securities:						
Residential	17	—	—	—	17	—
Commercial	193	(1)	43	—	236	(1)
Asset-backed securities	65	—	498	(2)	563	(2)
Corporate debt securities	342	(1)	16	—	358	(1)
Total debt securities	$ 1,057	$ (4)	$ 576	$ (2)	$ 1,633	$ (6)

Approximately 95% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2021. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 1% of our total debt securities. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Our unrealized loss from all debt securities was generated from approximately 720 positions out of a total of approximately 1,730 positions at December 31, 2021. All issuers of debt securities we own that were trading at an unrealized loss at December 31, 2021 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2021, we did not intend to sell any debt securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these debt securities before recovery of their amortized cost basis. Additionally, we did not record any material credit allowances for debt securities that were in an unrealized loss position at December 31, 2021 or 2020.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2021, 2020, and 2019:

	2021	2020	2019
		(in millions)	
Gross gains on investment securities	$ 219	$ 110	$ 129
Gross losses on investment securities	(8)	(18)	(67)
Gross gains on equity securities	23	746	—
Gross losses on equity securities	(364)	—	—
Net recognized (losses) gains on investment securities	$ (130)	$ 838	$ 62

The gains and losses related to equity securities for the years ended December 31, 2021 and 2020 was as follows:

	2021	2020
	(in millions)	
Net (losses) gains recognized on equity securities during the period	$ (341)	$ 746
Less: Net losses recognized on equity securities sold during the period	(13)	—
Unrealized (losses) gains recognized on equity securities still held at the end of the period	$ (328)	$ 746

All purchases of and proceeds from investment securities for the years ended December 31, 2020 and 2019 relate to debt securities.

There were no material other-than-temporary impairments in 2019.

The contractual maturities of debt securities available for sale at December 31, 2021, 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	$ 459	$ 461
Due after one year through five years	2,200	2,251
Due after five years through ten years	3,043	3,057
Due after ten years	1,360	1,374
Mortgage and asset-backed securities	6,378	6,354
Total debt securities	$ 13,440	$ 13,497

6. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2021 and 2020, 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, 2021				
Cash equivalents	$ 3,322	$ 3,322	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	602	—	602	—
Mortgage-backed securities	3,229	—	3,229	—
Tax-exempt municipal securities	841	—	841	—
Mortgage-backed securities:				
Residential	367	—	367	—
Commercial	1,410	—	1,410	—
Asset-backed securities	1,348	—	1,348	—
Corporate debt securities	5,700	—	5,632	68
Total debt securities	13,497	—	13,429	68
Common stock	475	475	—	—
Total invested assets	$ 17,294	$ 3,797	$ 13,429	$ 68
December 31, 2020				
Cash equivalents	$ 4,548	$ 4,548	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	616	—	616	—
Mortgage-backed securities	3,254	—	3,254	—
Tax-exempt municipal securities	1,447	—	1,447	—
Mortgage-backed securities:				
Residential	17	—	17	—
Commercial	1,318	—	1,318	—
Asset-backed securities	1,372	—	1,372	—
Corporate debt securities	4,927	—	4,927	—
Total debt securities	12,951	—	12,951	—
Common stock	815	815	—	—
Total invested assets	$ 18,314	$ 5,363	$ 12,951	$ —

Our Level 3 assets had a fair value of $68 million at December 31, 2021, or 0.4% of our total invested assets. During the year ended December 31, 2021, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the year ended December 31, 2021	
	Private Placements	
	(in millions)	
Beginning balance at January 1	$	—
Total gains or losses:		
Realized in earnings		—
Unrealized in other comprehensive income		(1)
Purchases		69
Sales		—
Settlements		—
Balance at December 31	$	68

Financial Liabilities

Our debt is recorded at carrying value in our consolidated balance sheets. The carrying value of our senior notes debt outstanding, net of unamortized debt issuance costs, was $9.0 billion at December 31, 2021 and $6.1 billion at December 31, 2020. The fair value of our senior note debt was $10.0 billion at December 31, 2021 and $7.4 billion at December 31, 2020. The fair value of our senior note debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities. Carrying value approximates fair value for our term loans and commercial paper borrowings. The term loan and commercial paper borrowings were $3.5 billion at December 31, 2021. Our commercial paper borrowings were $600 million at December 31, 2020.

Put and Call Options Measured at Fair Value

Our put and call options associated with our equity method investments are measured at fair value each period using a Monte Carlo simulation.

Effective April 27, 2021, with the signing of the definitive agreement to acquire the remaining 60% interest of KAH, the respective put and call options were terminated. As such, the $63 million put and $440 million call fair values as of the first quarter of 2021 were reduced to zero, resulting in $377 million in "Other (income) expense, net" in our consolidated statements of income for the year ended December 31, 2021.

The put and call options were measured at fair value using a Monte Carlo simulation which resulted in fair values of $45 million and $503 million, respectively, at December 31, 2020. The put option was included within other long-term liabilities and the call option included within other long-term assets at December 31, 2020. The change in fair value of the put and call options is reflected as "Other (income) expense, net" in our consolidated statements of income.

The significant unobservable inputs utilized in these Level 3 fair value measurements (and selected values) include the enterprise value of KAH, annualized volatility and secured credit rate. Enterprise value was derived from a discounted cash flow model, which utilized significant unobservable inputs for long-term net operating profit after tax margin, or NOPAT, to measure underlying cash flows, weighted average cost of capital and long term growth rate. The table below presents the assumptions used for December 31, 2020.

	December 31, 2020
Annualized volatility	29.9 %
Secured credit rate	0.4 %
NOPAT	12.0 %
Weighted average cost of capital	9.5 %
Long term growth rate	3.0 %

The put and call options fair values associated with our Primary Care Organization strategic partnership with WCAS, which are exercisable at a fixed revenue exit multiple and provide a minimum return on WCAS' investment if exercised, are measured at fair value each reporting period using a Monte Carlo simulation. The put and call options fair values, derived from the Monte Carlo simulation, were $202 million and $13 million, respectively, at December 31, 2021. The put and call options fair values, derived from the Monte Carlo simulation, were $64 million and $15 million, respectively, at December 31, 2020.

The significant unobservable inputs utilized in these Level 3 fair value measurements (and selected values) include the enterprise value, annualized volatility and credit spread. Enterprise value was derived from a discounted cash flow model, which utilized significant unobservable inputs for long-term revenue, to measure underlying cash flows, weighted average cost of capital and long term growth rate. The table below presents the assumptions used for December 31, 2021.

	December 31, 2021
Annualized volatility	22.4 %
Credit spread	0.9 %
Revenue exit multiple	1.5x - 2.5x
Weighted average cost of capital	12.5 %
Long term growth rate	3.0 %

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

Certain assets and liabilities are measured at fair value on a non-recurring basis subject to fair value adjustment only in certain circumstances. As disclosed in Note 3, “Acquisitions”, we completed our acquisition of KAH during the third quarter of 2021. The net assets acquired and resulting goodwill and other intangible assets were recorded at fair value primarily using Level 3 inputs. The net tangible assets including receivables and accrued liabilities were recorded at their carrying value which approximated their fair value due to their short term nature. The fair value of goodwill and other intangible assets were internally estimated based on the income approach. The income approach estimates fair value based on the present value of cash flow that the assets could be expected to generate in the future. We developed internal estimates for expected cash flows in the present value calculation using inputs and significant assumptions that include historical revenues and earnings, long-term growth rate, discount rate, contributory asset charges and future tax rates, among others. The excess purchase price over the fair value of assets and liabilities acquired is recorded as goodwill.

Other than the assets acquired and liabilities assumed in the KAH and other acquisitions in Note 3, there were no other material assets or liabilities measured at fair value on a recurring or nonrecurring basis during 2021, 2020, or 2019.

7. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2021 and 2020. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2021		2020	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 363	$ 1,894	$ 216	$ 1,420
Trade accounts payable and accrued expenses	(68)	(466)	(39)	(253)
Net current asset	295	1,428	177	1,167
Other long-term assets	5	—	8	—
Other long-term liabilities	(194)	—	(90)	—
Net long-term liability	(189)	—	(82)	—
Total net asset	$ 106	$ 1,428	$ 95	$ 1,167

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2021 and 2020.

	2021	2020
	(in millions)	
Land	$ 17	$ 19
Buildings and leasehold improvements	1,126	952
Equipment	1,148	1,009
Computer software	3,656	3,514
	5,947	5,494
Accumulated depreciation	(2,874)	(3,123)
Property and equipment, net	$ 3,073	$ 2,371

Depreciation expense was $640 million in 2021, $528 million in 2020, and $505 million in 2019, including amortization expense for capitalized internally developed and purchased software of $443 million in 2021, $351 million in 2020, and $343 million in 2019.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2021 and 2020 were as follows:

	Retail	Group and Specialty	Healthcare Services	Total
	(in millions)			
Balance at January 1, 2020	$ 1,535	$ 261	$ 2,132	$ 3,928
Acquisitions	—	—	519	519
Balance at December 31, 2020	1,535	261	2,651	4,447
Acquisitions	398	—	6,247	6,645
Balance at December 31, 2021	$ 1,933	$ 261	$ 8,898	$ 11,092

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, 2021 and 2020.

	Weighted Average Life	2021 Cost	2021 Accumulated Amortization	2021 Net	2020 Cost	2020 Accumulated Amortization	2020 Net
		(in millions)					
Other intangible assets:							
Certificates of need	Indefinite	$ 1,771	$ —	$ 1,771	$ —	$ —	$ —
Medicare licenses	Indefinite	522	—	522	—	—	—
Customer contracts/relationships	9.4 years	883	620	263	849	572	277
Trade names and technology	7.0 years	160	97	63	122	89	33
Provider contracts	11.6 years	72	57	15	69	50	19
Noncompetes and other	6.8 years	35	30	5	29	29	—
Total other intangible assets	9.1 years	$ 3,443	$ 804	$ 2,639	$ 1,069	$ 740	$ 329

Amortization expense for other intangible assets was approximately $65 million in 2021, $88 million in 2020, and $70 million in 2019.

The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
2022	$ 68
2023	53
2024	45
2025	43
2026	31

10. LEASES

We determine if a contract contains a lease by evaluating the nature and substance of the agreement. We lease facilities, computer hardware, and other furniture and equipment. Leases with an initial term of 12 months or less are not recorded on the balance sheet; we recognize lease expense for these leases on a straight-line basis over the lease term. For new lease agreements, we combine lease and nonlease components for all of our asset classes.

When portions of the lease payments are not fixed or depend on an index or rate, we consider those payments to be variable in nature. Our variable lease payments include, but are not limited to, common area maintenance, taxes and insurance which are not dependent upon an index or rate. Variable lease payments are recorded in the period in which the obligation for the payment is incurred. Most leases include options to renew, with renewal terms that can extend the lease term. The exercise of lease renewal options is at our sole discretion. Certain leases also include options to purchase the leased property. The depreciable life of assets and leasehold improvements are limited by the expected lease term, unless there is a transfer of title or purchase option reasonably certain of exercise. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

Right-of-use assets included within other long-term assets in our consolidated balance sheets were $678 million and $437 million at December 31, 2021 and December 31, 2020, respectively. Operating lease liabilities included within trade accounts payable and accrued expenses were $185 million and $129 million at December 31, 2021 and December 31, 2020, respectively. Additionally, operating lease liabilities included within other long-term liabilities were $546 million and $355 million at December 31, 2021 and December 31, 2020, respectively. The classification of our operating lease liabilities is based on the remaining lease term.

For the years ended December 31, 2021 and December 31, 2020, total fixed operating lease costs, excluding short-term lease costs, were $159 million and $141 million, respectively, and are included within operating costs in our consolidated statements of income. Short-term lease costs were not material for the years ended December 31, 2021 and December 31, 2020. In addition, for the years ended December 31, 2021 and December 31, 2020, total variable operating lease costs were $94 million and $92 million, respectively, and are included within operating costs in our consolidated statements of income.

We sublease facilities or partial facilities to third party tenants for space not used in our operations. For the years ended December 31, 2021 and December 31, 2020, sublease rental income was $43 million and $36 million, respectively, and is included within operating costs in our consolidated statements of income.

The weighted average remaining lease term is 5.4 years and 5.2 years with a weighted average discount rate of 3.2% and 3.7% at December 31, 2021 and December 31, 2020, respectively. For the year-ended December 31, 2021 and December 31, 2020, cash paid for amounts included in the measurement of lease liabilities included within our operating cash flows was $165 million and $146 million, respectively.

Maturity of Lease Liabilities	**December 31, 2021**
For the years ended December 31,	**(in millions)**
2022	$ 210
2023	170
2024	133
2025	105
2026	58
After 2026	129
Total lease payments	805
Less: Interest	74
Present value of lease liabilities	$ 731

As most of our leases do not provide an implicit rate, we use our incremental borrowing rate, as adjusted for collateralized borrowings, based on the information available at date of adoption or commencement date in determining the present value of lease payments.

11. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable was as follows for the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019
		(in millions)	
Balances at January 1	$ 8,143	$ 6,004	$ 4,862
Less: Reinsurance recoverables	—	(68)	(95)
Balances at January 1, net	8,143	5,936	4,767
Acquisitions	42	—	—
Incurred related to:			
Current year	70,024	61,941	54,193
Prior years	(825)	(313)	(336)
Total incurred	69,199	61,628	53,857
Paid related to:			
Current year	(62,149)	(54,003)	(48,421)
Prior years	(6,946)	(5,418)	(4,267)
Total paid	(69,095)	(59,421)	(52,688)
Reinsurance recoverable	—	—	68
Balances at December 31	$ 8,289	$ 8,143	$ 6,004

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $825 million in 2021, $313 million in 2020, and $336 million in 2019. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2021, 2020, and 2019.

	(Favorable) Unfavorable Medical Claims Reserve Development		
	2021	2020	2019
		(in millions)	
Retail Segment	$ (729)	$ (266)	$ (386)
Group and Specialty Segment	(96)	(47)	50
Total	$ (825)	$ (313)	$ (336)

The medical claims reserve development for 2021, 2020, and 2019 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. In addition, the higher prior year favorable development for the year ended December 31, 2021 was primarily attributable to the reversal of actions taken in 2020, including the suspension of certain financial recovery programs for a period of time impacting our claim payment patterns. The suspension during 2020 was intended to provide financial and administrative relief for providers facing unprecedented strain as a result of the COVID-19 pandemic.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our segments as of December 31, 2021, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2020 and 2019 is presented as supplementary information.

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

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019
		(in millions)	
Balances at January 1	$ 7,428	$ 5,363	$ 4,338
Less: Reinsurance recoverables	—	(68)	(95)
Balances at January 1, net	7,428	5,295	4,243
Acquisitions	42	—	—
Incurred related to:			
Current year	65,636	56,821	48,983
Prior years	(729)	(266)	(386)
Total incurred	64,907	56,555	48,597
Paid related to:			
Current year	(58,363)	(49,586)	(43,831)
Prior years	(6,339)	(4,836)	(3,714)
Total paid	(64,702)	(54,422)	(47,545)
Reinsurance recoverable	—	—	68
Balances at December 31	$ 7,675	$ 7,428	$ 5,363

At December 31, 2021, benefits payable for our Retail segment included IBNR of approximately $5.2 billion, primarily associated with claims incurred in 2021. The cumulative number of reported claims as of December 31, 2021 was approximately 156.1 million for claims incurred in 2021, 140.4 million for claims incurred in 2020, and 129.1 million for claims incurred in 2019.

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2021, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	**2019 Unaudited**	**2020 Unaudited**	**2021**
		(in millions)	
2019	$ 48,983	$ 48,820	$ 48,713
2020		56,821	56,223
2021			65,678
Total			$ 170,614

	Cumulative Paid Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	**2019 Unaudited**	**2020 Unaudited**	**2021**
		(in millions)	
2019	$ 43,831	$ 48,627	$ 48,713
2020		49,586	55,863
2021			58,363
Total			162,939
All outstanding benefit liabilities before 2019, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 7,675

Group and Specialty Segment

Activity in benefits payable for our Group and Specialty segment, excluding military services, was as follows for the years ended December 31, 2021, 2020 and 2019:

	2021	**2020**	**2019**
		(in millions)	
Balances at January 1	$ 715	$ 641	$ 517
Incurred related to:			
Current year	5,047	5,576	5,708
Prior years	(96)	(47)	50
Total incurred	4,951	5,529	5,758
Paid related to:			
Current year	(4,445)	(4,873)	(5,081)
Prior years	(607)	(582)	(553)
Total paid	(5,052)	(5,455)	(5,634)
Balances at December 31	$ 614	$ 715	$ 641

At December 31, 2021, benefits payable for our Group and Specialty segment included IBNR of approximately $532 million, primarily associated with claims incurred in 2021. The cumulative number of reported claims as of December 31, 2021 was approximately 8.3 million for claims incurred in 2021, 9.1 million for claims incurred in 2020, and 10.1 million for claims incurred in 2019.

The following tables provide information about incurred and paid claims development for the Group and Specialty segment as of December 31, 2021, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	**2019 Unaudited**	**2020 Unaudited**	**2021**
		(in millions)	
2019	$ 5,708	$ 5,657	$ 5,652
2020		5,576	5,491
2021			5,047
Total			$ 16,190

	Cumulative Paid Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	**2019 Unaudited**	**2020 Unaudited**	**2021**
		(in millions)	
2019	$ 5,081	$ 5,465	$ 5,652
2020		4,873	5,479
2021			4,445
Total			15,576
All outstanding benefit liabilities before 2019, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 614

12. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019
		(in millions)	
Current provision:			
Federal	$ 466	$ 1,019	$ 560
States and Puerto Rico	4	93	41
Total current provision	470	1,112	601
Deferred expense	15	195	162
Provision for income taxes	$ 485	$ 1,307	$ 763

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2021, 2020 and 2019 due to the following:

	2021	2020	2019
		(in millions)	
Income tax provision at federal statutory rate	$ 718	$ 982	$ 729
States, net of federal benefit, and Puerto Rico	18	63	49
Tax exempt investment income	(3)	(5)	(6)
Nondeductible executive compensation	33	19	25
Non-taxable KAH gain	(264)	—	—
Health insurance industry fee	—	268	—
Other, net	(17)	(20)	(34)
Provision for income taxes	$ 485	$ 1,307	$ 763

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, 2021 and 2020 were as follows:

	Assets (Liabilities)	
	2021	2020
	(in millions)	
Net operating loss carryforward	$ 291	$ 32
Compensation and other accrued expense	186	171
Benefits payable	67	87
Deferred acquisition costs	33	26
Jobs tax credits	33	—
Other	25	11
Unearned revenues	8	12
Total deferred income tax assets	643	339
Valuation allowance	(65)	(37)
Total deferred income tax assets, net of valuation allowance	578	302
Depreciable property and intangible assets	(1,072)	(449)
Prepaid expenses	(102)	(91)
Investment securities	(98)	(418)
Future policy benefits payable	(4)	(3)
Total deferred income tax liabilities	(1,276)	(961)
Total net deferred income tax liabilities	$ (698)	$ (659)

All deferred tax liabilities and assets are classified as noncurrent in our consolidated balance sheets as other long-term liabilities at December 31, 2021 and 2020.

At December 31, 2021, we had approximately $930 million of federal net operating losses and approximately $1.7 billion of state and Puerto Rico net operating losses to carry forward. A portion of these loss carryforwards, if not used to offset future taxable income, will expire from 2025 through 2038. The balance of the net operating loss carryforwards has no expiration date. Due to limitations and uncertainty regarding our ability to use some of the loss carryforwards and certain other deferred tax assets, a valuation allowance of $65 million was established. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to recover these deferred tax assets.

We file income tax returns in the United States and Puerto Rico. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2019 and prior years. Our 2020 tax return is in the post-filing review period under the Compliance Assurance Process, or CAP. Our 2021 tax return is under advance review by the IRS under CAP. With a few exceptions, which are immaterial in the aggregate, we are no longer subject to state, local and foreign tax examinations for years before 2018. We are not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

13. DEBT

The carrying value of debt outstanding was as follows at December 31, 2021 and 2020:

	2021	2020
	(in millions)	
Short-term debt:		
Commercial paper	$ 955	$ 600
Senior notes:		
$600 million, 3.15% due December 1, 2022	599	—
$400 million, 2.90% due December 15, 2022	399	—
Total senior notes	998	—
Total short-term debt	$ 1,953	$ 600
Long-term debt:		
Senior notes:		
$600 million, 3.15% due December 1, 2022	—	598
$400 million, 2.90% due December 15, 2022	—	398
$1.5 billion, 0.65% due August 3, 2023	1,492	—
$600 million, 3.85% due October 1, 2024	598	598
$600 million, 4.50% due April 1, 2025	596	595
$750 million, 1.35% due February 3, 2027	742	—
$600 million, 3.95% due March 15, 2027	596	596
$500 million, 3.125% due August 15, 2029	496	495
$500 million, 4.875% due April 1, 2030	495	494
$750 million, 2.15% due February 3, 2032	741	—
$250 million, 8.15% due June 15, 2038	261	262
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	740	739
$400 million, 4.80% due March 15, 2047	395	396
$500 million, 3.95% due August 15, 2049	493	493
Term loans:		
Term loan, due October 29, 2023	2,000	—
Delayed draw term loan, due May 28, 2024	500	—
Total long-term debt	$ 10,541	$ 6,060

Maturities of the short-term and long-term debt for the years ending December 31, are as follows:

For the years ending December 31,	(in millions)
2022	$ 1,955
2023	3,500
2024	1,100
2025	600
2026	—
Thereafter	5,400

Senior Notes

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes contain a change of control provision that may require us to purchase the notes under certain circumstances.

In August 2021, we issued $1.5 billion of 0.650% unsecured senior notes due August 3, 2023, $750 million of 1.350% unsecured senior notes due February 3, 2027 and $750 million of 2.150% unsecured senior notes due February 3, 2032. Our net proceeds, reduced for the underwriters' discounts and commissions paid, were $2,984 million. We used the net proceeds, together with cash on hand and borrowings under our $500 million delayed draw term loan, to fund the purchase price of KAH and to pay related fees and expenses.

Delayed Draw Term Loan Credit Agreement

In May 2021, we entered into a $500 million unsecured delayed draw term loan credit agreement. Under the term loan credit agreement, loans bear interest at either LIBOR plus a spread or the base rate plus a spread. The loans under the term loan credit agreement mature on the third anniversary of the funding date. The LIBOR spread, currently 125 basis points, varies depending on our credit ratings ranging from 100.0 to 162.5 basis points. The term loan credit agreement provides for the transition from LIBOR and does not require amendment in connection with such transition.

In August 2021, we borrowed $500 million under the delayed draw term loan agreement, which was used, in combination with other debt financing, to fund the approximate $5.8 billion transaction price of Kindred at Home. The term loan credit agreement contains customary restrictive covenants and a financial covenant regarding maximum debt to capitalization of 60%, as well as customary events of default. We are in compliance with this financial covenant, with actual debt to capitalization of 43.7% as measured in accordance with the term loan credit agreement as of December 31, 2021.

We have other customary relationships, including financial advisory and banking, with some parties to the term loan agreement.

October 2021 Term Loan Agreement

On October 29, 2021, we entered into a $2.0 billion term loan credit agreement, which we refer to as the October 2021 Term Loan Agreement, with certain lending banks and other financial institutions. Proceeds of the October 2021 Term Loan Agreement were applied to finance the repayment in full of the outstanding KAH debt.

Loans under the October 2021 Term Loan Agreement bear interest at adjusted Term SOFR, as defined in the October 2021 Term Loan Agreement, or the base rate plus a spread. The applicable margin, currently 112.5 basis points, varies depending on our credit ratings ranging from 87.5 to 137.5 basis points. The loans under the October 2021 Term Loan Agreement will mature on October 29, 2023. The October 2021 Term Loan Agreement contains customary covenants, including a maximum debt to capitalization financial condition covenant regarding maximum debt to capitalization of 60%, as well as customary events of default. We are in compliance with this financial covenant, with actual debt to capitalization of 43.7% as measured in accordance with the term loan credit agreement as of December 31, 2021. We have other relationships, including financial advisory and banking, with some parties to the October 2021 Term Loan Agreement.

At the time of the repayment in full of the KAH debt, there was $1.9 billion of outstanding debt thereunder and no prepayment penalty was due.

Revolving Credit Agreements

In June 2021, we entered into two separate revolving credit agreements: (i) a 5-year, $2.5 billion unsecured revolving credit agreement and (ii) a 364-day $1.5 billion unsecured revolving credit agreement. Under the revolving credit agreements, 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 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 revolving credit agreements provide for the transition from LIBOR and do not require amendment in connection with such transition.

The LIBOR spread, currently 110.0 basis points under the 5-year revolving credit agreements and 115.0 basis points under the 364-day revolving credit agreement, varies depending on our credit ratings ranging from 91.0 to 140.0 basis points under the 5-year revolving credit agreement and from 93.0 to 145.0 basis points under the 364-day revolving credit agreement. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15.0 basis points, under the 5-year revolving credit agreement and 10.0 basis points under the 364-day revolving agreement, varies depending on our credit ratings ranging from 9.0 to 22.5 basis points under the 5-year revolving credit agreement and from 7.0 to 17.5 basis points under the 364-day revolving credit agreement.

The terms of the revolving credit agreements include standard provisions related to conditions of borrowing which could limit our ability to borrow additional funds. In addition, the credit agreements contain customary restrictive covenants and a financial covenant regarding maximum debt to capitalization of 60%, as well as customary events of default. We are in compliance with this financial covenant, with actual debt to capitalization of 43.7% as measured in accordance with the revolving credit agreements as of December 31, 2021. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the revolving credit agreements by up to $750 million in the aggregate, to a maximum of $4.75 billion, across the 5-year and 364-day revolving credit agreements.

At December 31, 2021, we had no borrowings and approximately $75 million of letters of credit outstanding under the revolving credit agreements, including those of KAH. Accordingly, as of December 31, 2021, we had $2.4 billion of remaining borrowing capacity under the 5-year revolving credit agreement and $1.5 billion of remaining borrowing capacity under the 364-day revolving credit agreement (which excludes the uncommitted $750 million of incremental loan facilities), none of which would be restricted by our financial covenant compliance requirement.

We have other customary relationships, including financial advisory and banking, with some parties to the revolving credit agreements.

Commercial Paper

Under our commercial paper program we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time. On February 10, 2022, we increased the size of our commercial paper program to permit the issuance of commercial paper notes in an aggregate principal amount not to exceed $4 billion compared to the prior amount not to exceed $2 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2021 was $1,155 million, with $955 million outstanding at December 31, 2021 compared to $600 million outstanding at December 31, 2020. The outstanding commercial paper at December 31, 2021 had a weighted average annual interest rate of 0.33%.

Other Short-term Borrowings

We are a member, through one subsidiary, of the Federal Home Loan Bank of Cincinnati, or FHLB. As a member we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2021 we had no outstanding short-term FHLB borrowings.

14. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $259 million in 2021, $236 million in 2020, and $221 million in 2019. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $463.86 on December 31, 2021, approximately 9% of the retirement and savings plan's assets were invested in our common stock, or approximately 1.4 million shares, representing approximately 1.1% of the shares outstanding as of December 31, 2021. At December 31, 2021, approximately 1.1 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. Awards generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. We have also granted awards to certain employees that vest upon a combination of time and performance-based conditions. The stock awards of retirement-eligible participants are generally earned ratably over the service period for each tranche. Accordingly, upon retirement the earned portion of the current tranche will continue to vest on the originally scheduled vest date and any remaining unearned portion of the award will be forfeited. Our equity award program includes a retirement provision that generally treats employees with a combination of age and years of services with the Company totaling 65 or greater, with a minimum required age of 55 and a minimum requirement of 5 years of service, as retirement-eligible. Upon exercise, stock-based compensation awards are settled with authorized but unissued company stock or treasury stock.

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2021, 2020, and 2019:

	2021	2020	2019
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 171	$ 171	$ 152
Stock options	9	10	11
Total stock-based compensation expense	180	181	163
Tax benefit recognized	(15)	(29)	(35)
Stock-based compensation expense, net of tax	$ 165	$ 152	$ 128

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $28 million in 2021, $32 million in 2020, and $25 million in 2019. There was no capitalized stock-based compensation expense during these years.

At December 31, 2021, there were 11.3 million shares reserved for stock award plans under the Humana Inc. 2011 Stock Incentive Plan, or 2011 Plan, and 15.7 million shares reserved for stock award plans under the Humana Inc. 2019 Stock Incentive Plan, or 2019 Plan. These reserved shares included giving effect to, under the 2011 Plan, 3.4 million shares of common stock available for future grants assuming all stock options were granted or 1.5 million shares available for future grants assuming all restricted stock were granted. These reserved shares included giving effect to, under the 2019 Plan, 12.6 million shares of common stock available for future grants assuming all stock options were granted or 3.8 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock grants also include performance-based conditions generally associated with return on invested capital and strategic membership growth. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $381.34 in 2021, $354.66 in 2020, and $302.09 in 2019. Activity for our restricted stock was as follows for the year ended December 31, 2021:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2020	911	$ 282.81
Granted	485	381.34
Vested	(460)	312.45
Forfeited	(63)	347.42
Nonvested restricted stock at December 31, 2021	873	$ 380.55

Approximately 35% of the nonvested restricted stock at December 31, 2021 included performance-based conditions.

The fair value of shares vested was $236 million during 2021, $191 million during 2020, and $141 million during 2019. Total compensation expense not yet recognized related to nonvested restricted stock was $192 million at December 31, 2021. We expect to recognize this compensation expense over a weighted-average period of approximately 1.8 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 years after grant.

The weighted-average fair value of each option granted during 2021, 2020, and 2019 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:

	2021	2020	2019
Weighted-average fair value at grant date	$ 92.21	$ 69.73	$ 68.53
Expected option life (years)	3.7 years	4.0 years	4.1 years
Expected volatility	33.8 %	24.9 %	25.5 %
Risk-free interest rate at grant date	0.4 %	1.2 %	2.4 %
Dividend yield	0.7 %	0.7 %	0.7 %

We calculate the expected term for our employee stock options based on historical employee exercise behavior and base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

The volatility used to value employee stock options is based on historical volatility. We calculate historical volatility using a simple-average calculation methodology based on daily price intervals as measured over the expected term of the option.

Activity for our option plans was as follows for the year ended December 31, 2021:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2020	323	$ 309.04
Granted	93	379.26
Exercised	(106)	282.35
Forfeited	—	—
Options outstanding at December 31, 2021	310	$ 339.08
Options exercisable at December 31, 2021	108	$ 308.22

As of December 31, 2021, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $39 million, and a weighted-average remaining contractual term of 4.8 years. As of December 31, 2021, exercisable stock options had an aggregate intrinsic value of $17 million, and a weighted-average remaining contractual term of 3.7 years. The total intrinsic value of stock options exercised during 2021 was $18 million, compared with $51 million during 2020 and $43 million during 2019. Cash received from stock option exercises totaled $30 million in 2021, $61 million in 2020, and $58 million in 2019.

Total compensation expense not yet recognized related to nonvested options was $9 million at December 31, 2021. We expect to recognize this compensation expense over a weighted-average period of approximately 1.5 years.

15. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019
		(dollars in millions, except per common share results, number of shares/options in thousands)	
Net income available for common stockholders	$ 2,933	$ 3,367	$ 2,707
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	128,688	132,199	134,055
Dilutive effect of:			
Employee stock options	64	92	107
Restricted stock	644	721	565
Shares used to compute diluted earnings per common share	129,396	133,012	134,727
Basic earnings per common share	$ 22.79	$ 25.47	$ 20.20
Diluted earnings per common share	$ 22.67	$ 25.31	$ 20.10
Number of antidilutive stock options and restricted stock awards excluded from computation	216	238	478

16. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2019, 2020, and 2021 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2019	$2.15	$289
2020	$2.43	$322
2021	$2.73	$351

In October 2021, the Board declared a cash dividend of $0.70 per share payable on January 28, 2022 to stockholders of record on December 31, 2021 for an aggregate amount of $90 million. In February 2022, the Board declared a cash dividend of $0.7875 per share payable on April 29, 2022 to stockholders of record on March 31, 2022. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

Stock Repurchases

Our Board of Directors may authorize the purchase of our common shares. Under our share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing.

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans.

On November 28, 2018, we entered into an accelerated stock repurchase agreement, the November 2018 ASR, with Goldman Sachs to repurchase $750 million of our common stock as part of the $3.0 billion share repurchase program authorized by the Board of Directors on December 14, 2017. On November 29, 2018, we made a payment of $750 million to Goldman Sachs from available cash on hand and received an initial delivery of 1.94 million shares of our common stock from Goldman Sachs. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $600 million increase in treasury stock, which reflected the value of the initial 1.94 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the November 2018 ASR. Upon final settlement of the November 2018 ASR on February 28, 2019, we received an additional 0.6 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $295.15, bringing the total shares received under this program to 2.54 million. In addition, upon settlement we reclassified the $150 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock.

On July 30, 2019, the Board of Directors replaced a previous share repurchase authorization of up to $3 billion (of which approximately $1.03 billion remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on June 30, 2022.

On July 31, 2019, we entered into an accelerated stock repurchase agreement, the July 2019 ASR, with Citibank, N.A., or Citi, to repurchase $1 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on July 30, 2019. On August 2, 2019, we made a payment of $1 billion to Citi and received an initial delivery of 2.7 million shares of our common stock. We recorded the payment to Citi as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 2.7 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by Citi pending final settlement of the July 2019 ASR. Upon final settlement of the July 2019 ASR on December 26, 2019, we received an additional 0.7 million shares as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $296.19, bringing the total shares received under the July 2019 ASR to 3.4 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by Citi from capital in excess of par value to treasury stock.

On December 22, 2020, we entered into separate accelerated stock repurchase agreements, ("the December 2020 ASR Agreements"), with Citibank, N.A., or Citi, and JPMorgan Chase Bank, or JPM, to repurchase $1.75 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on July 30, 2019. On December 23, 2020, in accordance with the December 2020 ASR Agreements, we made a payment of $1.75 billion ($875 million to Citi and $875 million to JPM) and received an initial delivery of 3.8 million shares of our common stock (1.9 million shares each from Citi and JPM). We recorded the payments to Citi and JPM as a reduction to stockholders' equity, consisting of an $1.5 billion increase in treasury stock, which reflects the value of the initial 3.8 million shares received upon initial settlement, and a $262.5 million decrease in capital in excess of par value, which reflects the value of stock held back by Citi and JPM pending final settlement of the December 2020 ASR Agreements. Upon final settlement of the December 2020 ASR agreements with Citi and JPM on May 4, 2021 and May 5, 2021, respectively, we received an additional 0.3 million shares and 0.3 million shares, respectively, as determined by the average daily volume weighted-averages share price of our common stock during the term of the agreement, less a discount, of $400.07 and $401.49, respectively, bringing the total shares received under the December 2020 ASR agreements to 4.4 million. In addition, upon settlement we reclassified the $262.5 million value of stock initially held back by Citi and JPM from capital in excess of par value to treasury stock.

On February 18, 2021, the Board of Directors replaced the previous share repurchase authorization of up to $3 billion (of which approximately $250 million remained unused) with a new authorization for repurchases of up to $3 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring as of February 18, 2024.

On January 11, 2022, we entered into separate accelerated stock repurchase agreements ("the January 2022 ASR Agreements"), with Mizuho Markets Americas LLC, or Mizuho, and Wells Fargo Bank, or Wells Fargo, to repurchase $1 billion of our common stock as part of the $3 billion repurchase program authorized by the Board of Directors on February 18, 2021. On January 12, 2022, in accordance with the January 2022 ASR Agreements, we made a payment of $1 billion ($500 million to Mizuho and $500 million to Wells Fargo) and received an initial delivery of 2.2 million shares of our common stock (1.08 million shares each from Mizuho and Wells Fargo). In January 2022, we recorded the payments to Mizuho and Wells Fargo as a reduction to stockholders' equity, consisting of an $850 million increase in treasury stock, which reflects the value of the initial 2.2 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflects the value of stock held back by Mizuho and Wells Fargo pending final settlement of the January 2022 ASR Agreements. The final number of shares that we may receive, or be required to remit, under the agreement, will be determined based on the daily volume-weighted average share price of our common stock over the term of the agreement, less a discount and subject to adjustments pursuant to the terms and conditions of the agreement. We expect final settlement under the agreement to occur during the first quarter of 2022. The agreement contains provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement of the agreement may be accelerated, extended, or terminated early by Mizuho, Wells Fargo or Humana as well as various acknowledgments and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our common stock from Mizuho and Wells Fargo or we may be required to make a payment. If we are obligated to make payment, we may elect to satisfy such obligation in cash or shares of our common stock. Our remaining repurchase authorization was $2 billion as of February 17, 2022.

Excluding shares acquired in connection with employee stock plans, share repurchases were as follows during the years ended December 31, 2021, 2020 and 2019.

		2021		2020		2019	
Authorization Date	**Purchase Not to Exceed**	**Shares**	**Cost**	**Shares**	**Cost**	**Shares**	**Cost**
				(in millions)			
February 2021	3,000	—	$ —	—	$ —	—	$ —
July 2019	3,000	—	—	3.80	1,750	3.40	1,000
Total repurchases		—	$ —	3.80	$ 1,750	3.40	$ 1,000

In connection with employee stock plans, we acquired 0.2 million common shares for $79 million in 2021, 0.2 million common shares for $70 million in 2020, and 0.2 million common shares for $70 million in 2019.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurance subsidiaries had aggregate statutory capital and surplus of approximately $9.6 billion and $9.4 billion as of December 31, 2021 and 2020, respectively, which exceeded aggregate minimum regulatory requirements of $7.6 billion and $7.0 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2022 is approximately $1.5 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $1.6 billion in 2021, $1.3 billion in 2020, and $1.8 billion in 2019.

17. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $656 million in 2022, $310 million in 2023, $192 million in 2024, $97 million in 2025, and $52 million in 2026. Purchase obligations exclude agreements that are cancellable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2021, we were not involved in any SPE transactions.

Guarantees and Indemnifications

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

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

Government Contracts

Our Medicare products, which accounted for approximately 82% of our total premiums and services revenue for the year ended December 31, 2021, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2022, and all of our product offerings filed with CMS for 2022 have been approved.

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

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2021, 75% of the risk score was calculated from claims data submitted through EDS. CMS will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

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

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the “Proposed Rule”) related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We believe that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and have provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial position, or cash flows.

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

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

Our state-based Medicaid business accounted for approximately 6% of our total premiums and services revenue for the year ended December 31, 2021 primarily serving members enrolled in Medicaid, and in certain circumstances members who qualify for both Medicaid and Medicare, under contracts with various states.

At December 31, 2021, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2021, primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract comprises 32 states and approximately six million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022, unless extended, and is subject to renewals on January 1 of each year during its term at the government's option.

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

Legal Proceedings and Certain Regulatory Matters

As previously disclosed, the Civil Division of the United States Department of Justice provided us with an information request in December 2014, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with the Department of Justice. These matters are expected to result in additional qui tam litigation.

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

Other Lawsuits and Regulatory Matters

Our current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance, health care delivery and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, statutory capital requirements, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, sales practices, and provision of care by our healthcare services businesses, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate and payment disputes, including disputes over reimbursement rates required by statute, disputes arising from competitive procurement process, general contractual matters, intellectual property matters, and challenges to subrogation practices. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

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

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extra contractual damages, care delivery malpractice, and claims arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for the contingencies discussed in the sections above to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because of the inherently unpredictable nature of legal proceedings, which also may be exacerbated by various factors, including: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows, and may also affect our reputation.

18. SEGMENT INFORMATION

We manage our business with three reportable segments: Retail, Group and Specialty, and Healthcare Services. The reportable segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer, the Chief Operating Decision Maker, to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible demonstration, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes our military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes pharmacy, provider, and home services, along with other services and capabilities to promote wellness and advance population health. The operations of the recently acquired full ownership of Kindred at Home, as well as the company's strategic partnership with Welsh, Carson, Anderson & Stowe (WCAS) to develop and operate senior-focused, payor-agnostic, primary care centers are also included in the Healthcare Services segment.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of Humana Pharmacy, Inc., our mail order pharmacy business. These revenues consist of the prescription price (ingredient cost plus dispensing fee), including the portion to be settled with the member (co-share) or with the government (subsidies), plus any associated administrative fees. Services revenues related to the distribution of prescriptions by third party retail pharmacies in our networks are recognized when the claim is processed and product revenues from dispensing prescriptions from our mail order pharmacies are recorded when the prescription or product is shipped. Our pharmacy operations, which are responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims, act as a principal in the arrangement on behalf of members in our other segments. As principal, our Healthcare Services segment reports revenues on a gross basis, including co-share amounts from members collected by third party retail pharmacies at the point of service.

In addition, our Healthcare Services intersegment revenues include revenues earned by certain owned providers derived from risk-based and non-risk-based managed care agreements with our health plans. Under risk based agreements, the provider receives a monthly capitated fee that varies depending on the demographics and health status of the member, for each member assigned to these owned providers by our health plans. The owned provider assumes the economic risk of funding the assigned members' healthcare services. Under non risk-based agreements, our health plans retain the economic risk of funding the assigned members' healthcare services. Our Healthcare Services segment reports provider services revenues associated with risk-based agreements on a gross basis, whereby capitation fee revenue is recognized in the period in which the assigned members are entitled to receive healthcare services. Provider services revenues associated with non-risk-based agreements are presented net of associated healthcare costs.

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $18.1 billion in 2021, $16.5 billion in 2020, and $14.9 billion in 2019. 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 $108 million in 2021, $127 million in 2020, and $117 million in 2019.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home services, to our Retail and Group and Specialty segment customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations in the tables presenting segment results below.

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, were approximately 83% for 2021, 83% for 2020 and 82% for 2019.

	Retail	Group and Specialty	Healthcare Services	Eliminations/ Corporate	Consolidated
			(in millions)		
2021					
External revenues					
Premiums:					
Individual Medicare Advantage	$ 58,654	$ —	$ —	$ —	$ 58,654
Group Medicare Advantage	6,955	—	—	—	6,955
Medicare stand-alone PDP	2,371	—	—	—	2,371
Total Medicare	67,980	—	—	—	67,980
Fully-insured	731	4,271	—	—	5,002
Specialty	—	1,731	—	—	1,731
Medicaid and other	5,109	—	—	—	5,109
Total premiums	73,820	6,002	—	—	79,822
Services revenue:					
Home Solutions	—	—	1,166	—	1,166
Provider	—	—	413	—	413
ASO and other	23	816	—	—	839
Pharmacy	—	—	637	—	637
Total services revenue	23	816	2,216	—	3,055
Total external revenues	73,843	6,818	2,216	—	82,877
Intersegment revenues					
Services	1	40	19,998	(20,039)	—
Products	—	—	9,024	(9,024)	—
Total intersegment revenues	1	40	29,022	(29,063)	—
Investment income	200	14	4	(31)	187
Total revenues	74,044	6,872	31,242	(29,094)	83,064
Operating expenses:					
Benefits	64,907	4,951	—	(659)	69,199
Operating costs	6,764	1,687	29,801	(28,131)	10,121
Depreciation and amortization	436	85	177	(102)	596
Total operating expenses	72,107	6,723	29,978	(28,892)	79,916
Income (loss) from operations	1,937	149	1,264	(202)	3,148
Interest expense	—	—	—	326	326
Other income, net	—	—	—	(532)	(532)
Income before income taxes and equity in net earnings	1,937	149	1,264	4	3,354
Equity in net earnings	—	—	65	—	65
Segment earnings	$ 1,937	$ 149	$ 1,329	$ 4	$ 3,419
Less: noncontrolling interests	—	—	(1)	—	(1)
Segment earnings attributable to Humana	$ 1,937	$ 149	$ 1,328	$ 4	$ 3,418

	Retail	Group and Specialty	Healthcare Services	Eliminations/ Corporate	Consolidated
			(in millions)		
2020					
External revenues					
Premiums:					
Individual Medicare Advantage	$ 51,697	$ —	$ —	$ —	$ 51,697
Group Medicare Advantage	7,774	—	—	—	7,774
Medicare stand-alone PDP	2,742	—	—	—	2,742
Total Medicare	62,213	—	—	—	62,213
Fully-insured	688	4,761	—	602	6,051
Specialty	—	1,699	—	—	1,699
Medicaid and other	4,223	—	—	—	4,223
Total premiums	67,124	6,460	—	602	74,186
Services revenue:					
Home Solutions	—	—	107	—	107
Provider	—	—	328	—	328
ASO and other	19	780	—	—	799
Pharmacy	—	—	581	—	581
Total services revenue	19	780	1,016	—	1,815
Total external revenues	67,143	7,240	1,016	602	76,001
Intersegment revenues					
Services	—	29	19,491	(19,520)	—
Products	—	—	7,928	(7,928)	—
Total intersegment revenues	—	29	27,419	(27,448)	—
Investment income	155	16	13	970	1,154
Total revenues	67,298	7,285	28,448	(25,876)	77,155
Operating expenses:					
Benefits	56,537	5,529	—	(438)	61,628
Operating costs	7,402	1,818	27,395	(26,563)	10,052
Depreciation and amortization	342	81	183	(117)	489
Total operating expenses	64,281	7,428	27,578	(27,118)	72,169
Income (loss) from operations	3,017	(143)	870	1,242	4,986
Interest expense	—	—	—	283	283
Other expense, net	—	—	—	103	103
Income (loss) before income taxes and equity in net earnings	3,017	(143)	870	856	4,600
Equity in net earnings	—	—	74	—	74
Segment earnings (loss)	$ 3,017	$ (143)	$ 944	$ 856	$ 4,674

	Retail	Group and Specialty	Healthcare Services	Eliminations/ Corporate	Consolidated
			(in millions)		
2019					
External revenues					
Premiums:					
Individual Medicare Advantage	$ 43,128	$ —	$ —	$ —	$ 43,128
Group Medicare Advantage	6,475	—	—	—	6,475
Medicare stand-alone PDP	3,165	—	—	—	3,165
Total Medicare	52,768	—	—	—	52,768
Fully-insured	588	5,123	—	—	5,711
Specialty	—	1,571	—	—	1,571
Medicaid and other	2,898	—	—	—	2,898
Total premiums	56,254	6,694	—	—	62,948
Services revenue:					
Home Solutions	—	—	140	—	140
Provider	—	—	306	—	306
ASO and other	17	790	—	—	807
Pharmacy	—	—	186	—	186
Total services revenue	17	790	632	—	1,439
Total external revenues	56,271	7,484	632	—	64,387
Intersegment revenues					
Services	—	18	18,255	(18,273)	—
Products	—	—	6,894	(6,894)	—
Total intersegment revenues	—	18	25,149	(25,167)	—
Investment income	195	23	2	281	501
Total revenues	56,466	7,525	25,783	(24,886)	64,888
Operating expenses:					
Benefits	48,602	5,758	—	(503)	53,857
Operating costs	5,306	1,651	24,852	(24,428)	7,381
Depreciation and amortization	323	88	156	(109)	458
Total operating expenses	54,231	7,497	25,008	(25,040)	61,696
Income from operations	2,235	28	775	154	3,192
Interest expense	—	—	—	242	242
Other income, net	—	—	—	(506)	(506)
Income before income taxes and equity in net earnings	2,235	28	775	418	3,456
Equity in net earnings	—	—	14	—	14
Segment earnings	$ 2,235	$ 28	$ 789	$ 418	$ 3,470

19. REINSURANCE

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

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

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Reinsurance recoverables, included in other current and long-term assets, were $188 million at December 31, 2021 and $194 million at December 31, 2020. The amount of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately $188 million at December 31, 2021 and approximately $193 million at December 31, 2020. Premiums ceded were $6 million in 2021, $29 million in 2020 and $1 billion in 2019. Benefits ceded were $2 million in 2021, $7 million in 2020, and $881 million in 2019. Ceded premium and benefits in 2019 reflect the activity associated with ceding all risk under a Medicaid contract to a third party reinsurer. The reinsurance agreement ceding all risk under the Medicaid contract was terminated effective January 1, 2020.

We evaluate the financial condition of our reinsurers on a regular basis. Protective Life Insurance Company with $169 million in reinsurance recoverables is well-known and well-established with a AM Best rating of A+ at December 31, 2021. The remaining reinsurance recoverables of $19 million are divided between 10 other reinsurers, with $2 million subject to funds withheld accounts or other financial guarantees supporting the repayment of these amounts.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Humana Inc. and its subsidiaries (the "Company") as of December 31, 2021 and 2020, and the related consolidated statements of income, of comprehensive income, of stockholders' equity and of cash flow for each of the three years in the period ended December 31, 2021, including the related notes and financial statement schedules listed in the index appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2021, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2021, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

As described in Management's Report on Internal Control over Financial Reporting, management has excluded Kindred at Home from its assessment of internal control over financial reporting as of December 31, 2021 because it was acquired by the Company in a purchase business combination during 2021. We have also excluded Kindred at Home from our audit of internal control over financial reporting. Kindred at Home is a wholly-owned subsidiary whose total assets and total revenues excluded from management's assessment and our audit of internal control over financial reporting represent 2% and 1%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2021.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Incurred but not yet Reported Benefits Payable

As described in Notes 2 and 11 to the consolidated financial statements, the Company's incurred but not yet reported benefits payable (IBNR) was $5.7 billion as of December 31, 2021. Management develops its estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. As described by management, for the periods prior to the most recent two months, a completion factor method uses historical paid claims patterns to estimate the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. Changes in claim inventory levels and known changes in claim payment processes are taken into account in these estimates. For the most recent two months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from historical experience in the preceding months, adjusted for known changes in estimates of hospital admissions, recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix and workday seasonality.

The principal considerations for our determination that performing procedures relating to the valuation of IBNR is a critical audit matter are the significant judgment by management when developing the estimate of IBNR, which in turn led to a high degree of auditor judgment, subjectivity and effort in performing procedures and evaluating the actuarial methodologies and significant assumptions related to completion factors, per member per month claims trends, and the potential for moderately adverse conditions. Also, the audit effort involved the use of professionals with specialized skill and knowledge.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of IBNR, including controls over the actuarial methodologies and development of significant assumptions related to completion factors, per member per month claims trends, and the potential for moderately adverse conditions. These procedures also included, among others, the involvement of professionals with specialized skill and knowledge to assist in developing an independent estimate of IBNR. This independent estimate includes a range of reasonable outcomes, including outcomes under moderately adverse conditions, which are compared to management’s estimate of IBNR. Developing the independent estimate involved developing independent completion factors and per member per month claims trends assumptions using management’s data, testing the completeness and accuracy of data provided by management, and evaluating the reasonableness of management’s assumptions.

Goodwill Impairment Assessments – Provider and Home Solutions Reporting Units

As described in Notes 2 and 9 to the consolidated financial statements, the Company’s consolidated goodwill balance was $11.1 billion as of December 31, 2021, and the goodwill associated with the Provider and Home Solutions Reporting Units was $0.9 billion and $6.6 billion, respectively. Management conducts an impairment test in the fourth quarter of each year and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. Management relies on an evaluation of future discounted cash flows analysis to determine fair value and uses discount rates that correspond to a market-based weighted-average cost of capital, and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in management’s cash flow projections, including revenue growth rates, medical and operating cost trends, and projected operating income, are supported with management’s long-range business plan and annual planning process.

The principal considerations for our determination that performing procedures relating to the goodwill impairment assessments of the Provider and Home Solutions reporting units is a critical audit matter are the significant judgment by management when determining the fair value of the reporting units, which in turn led to a high degree of auditor judgment, subjectivity, and effort in performing procedures and evaluating management’s significant assumptions related to the revenue and terminal growth rates, projected operating income, and the discount rates. Also, the audit effort involved the use of professionals with specialized skill and knowledge.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management’s goodwill impairment assessments, including controls over the significant assumptions used in the valuation of the Provider and Home Solutions reporting units. These procedures also included, among others, testing management's process for determining the fair value estimate of the reporting units; evaluating the appropriateness of the discounted cash flows analysis; testing the completeness and accuracy of underlying data used in the analysis; and evaluating the reasonableness of the significant assumptions used by management related to the revenue and terminal growth rates, projected operating income, and the discount rates. Evaluating management’s assumptions related to revenue and terminal growth rates and projected operating income involved considering the past performance of the reporting units and whether the assumptions were consistent with evidence obtained in other areas of the audit. Professionals with specialized skill and knowledge were used to assist in the evaluation of the appropriateness of the Company’s discounted cash flows analysis and the reasonableness of the significant assumptions related to the terminal growth rates and the discount rates.

Acquisition of Kindred at Home – Valuation of Certificate of Need Intangible Assets

As described in Notes 3, 6 and 9 to the consolidated financial statements, in August 2021, the Company acquired the remaining 60% interest in Kindred at Home for an enterprise value of $8.2 billion, which resulted in $1.8 billion of certificate of need intangible assets being recorded. Management developed its estimate of the fair value of the certificate of need intangible assets acquired based on the income approach, which involved the use of inputs and significant assumptions including historical revenues and earnings, long-term growth rate, discount rate, contributory asset charges and future tax rates, among others.

The principal considerations for our determination that performing procedures relating to the valuation of the Kindred at Home certificate of need intangible assets acquired is a critical audit matter are the significant judgment by management when developing the fair value, which in turn led to a high degree of auditor judgment, subjectivity, and effort in performing procedures and evaluating management’s significant assumptions related to long-term growth rate and discount rate. Also, the audit effort involved the use of professionals with specialized skill and knowledge.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the acquisition accounting, including controls over the valuation methodologies and the development of significant assumptions related to the valuation of the certificate of need intangible assets, including long-term growth rate and discount rate. These procedures also included, among others, reading the purchase agreement and testing management’s process for estimating the fair value of certificate of need intangible assets. Testing management’s process included evaluating the appropriateness of the income method and the reasonableness of the significant assumptions related to long-term growth rate and discount rate. Evaluating the reasonableness of the long-term growth rate involved considering the past performance of the acquired business, the Company’s historical results, and whether the assumptions were consistent with evidence obtained in other areas of the audit. Professionals with specialized skill and knowledge were used to assist in the evaluation of the appropriateness of the income method and the reasonableness of significant assumptions related to the long-term growth rate and discount rate.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 17, 2022

We have served as the Company’s auditor since 1968.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2021, which excluded the impact of the acquisition of Kindred at Home, or KAH, discussed below, we as the principal executive officer, the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

On August 17, 2021, we acquired the remaining 60% interest in KAH. We excluded KAH in our evaluation of internal controls over financial reporting and related disclosure controls and procedures. Total KAH assets and revenues excluded from our evaluation represent 2% and 1%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2021.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2021, which excluded the impact of the acquisition of KAH mentioned above. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2021, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting, which excluded the impact of the acquisition of KAH mentioned above, as of December 31, 2021 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on pages 122-125.

Changes in Internal Control over Financial Reporting

Other than the KAH acquisition mentioned above, there have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2021 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not applicable.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2022 appearing under the caption "Proposal One: Election of Directors" in such Definitive Proxy Statement.

Executive Officers of the Registrant

A list of our executive officers and biographical information appears in Part I, Item 1 of this Form 10-K.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day (the "Code"). All employees and directors are required to annually affirm in writing their acceptance of the Code. The Code was adopted by our Board of Directors in June 2014, replacing a previous iteration, known as the Humana Inc. Principles of Business Ethics, as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Code is available on the Investor Relations section of our web site at www.humana.com, and any waiver of the application of the Code with respect to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on the Investor Relations section of our Internet web site at www.humana.com is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors, pursuant to our Corporate Governance Guidelines;
- the pre-approval process of non-audit services provided by our independent accountants;
- our By-laws and Certificate of Incorporation;
- our Majority Vote policy, pursuant to our By-laws;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;

- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2022.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2022 appearing under the caption "Corporate Governance – Audit Committee" of such Definitive Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2022 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Definitive Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2022.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, and key employees. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2021 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights		(b) Weighted-average exercise price of outstanding options, warrants and rights		(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	309,603	$	339.080	$	16,039,025	(2)(3)(4)
Equity compensation plans not approved by security holders	—		—		—	
Total	309,603	$	339.080	$	16,039,025	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 14.
(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) The Humana Inc. Amended and Restated Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 18, 2019. On May 1, 2019, 16 million shares were registered with the Securities and Exchange Commission on Form S-8.
(4) Of the number listed above, 5,263,632 (1,503,912 from the 2011 Plan and 3,759,720 from the Amended and Restated Plan) can be issued as restricted stock at December 31, 2021 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan and 3.35 stock options in the Amended and Restated Plan).

The information under the captions "Stock Ownership Information - Security Ownership of Certain Beneficial Owners of Company Common Stock" and "Stock Ownership Information - Security Ownership of Directors and Executive Officers" in our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2022, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2022 appearing under the captions "Certain Transactions with Management and Others" and "Corporate Governance – Director Independence" of such Definitive Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Definitive Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2022 appearing under the caption "Audit Committee Report" of such Definitive Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, Report of Independent Registered Public Accounting Firm (PCAOB ID 238), financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Condensed Financial Information at December 31, 2021 and 2020 and for the years ended December 31, 2021, 2020 and 2019
Schedule II	Valuation and Qualifying Accounts for the years ended December 31, 2021, 2020 and 2019

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) Humana Inc. Amended and Restated By-Laws of Humana Inc., effective as of December 14, 2017 (incorporated herein by reference to Exhibit 3(b) to Humana Inc.'s Current Report on Form 8-K filed on December 14, 2017).

4(a) Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(b) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(c) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006, Req. No. 333-132878).

(d) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 13 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.

(e) Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(f) Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(g) Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(h)	Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(i)	Tenth Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017).
(j)	Eleventh Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017).
(k)	Thirteenth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017).
(l)	Fourteenth Supplemental Indenture, dated August 15, 2019, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on August 15, 2019).
(m)	Fifteenth Supplemental Indenture, dated August 15, 2019, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on August 15, 2019).
(n)	Sixteenth Supplemental Indenture, dated March 26, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K, filed March 27, 2020).
(o)	Seventeenth Supplemental Indenture, dated March 26, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K, filed March 27, 2020).
(p)	Eighteenth Supplemental Indenture, dated August 3, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on August 3, 2021).
(q)	Nineteenth Supplemental Indenture, dated August 3, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on August 3, 2021).
(r)	Twentieth Supplemental Indenture, dated August 3, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on August 3, 2021).
(s)	Description of Securities (incorporated herein by reference to Exhibit 4(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10(a)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(b)*	Humana Inc. Executive Incentive Compensation Plan, as amended and restated January 1, 2020 (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2020).
(c)*	Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999, File No. 001-05975).

(d)* The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).

(e)* Humana Inc. Executive Severance Policy, effective as of March 1, 2019 (incorporated herein by reference to Exhibit 10(f) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).

(f)* Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).

(g)* Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 18, 2011).

(h)* Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994, File No. 001-05975).

(i)* Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).

(j)* Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).

(k)* Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013).

(l) Five-Year $2.5 Billion Amended and Restated Credit Agreement, dated as of June 4, 2021, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent and as CAF Loan Agent, Bank of America, N.A. and Goldman Sachs Bank USA as Syndication Agents, Citibank, N.A., PNC Capital Markets LLC, National Association, U.S. Bank, National Association and Wells Fargo Securities, LLC, as Documentation Agents, and JPMorgan Chase Bank, N.A., BofA Securities, Inc., Goldman Sachs Bank USA, Citibank, N.A., PNC Capital Markets LLC, U.S. Bank, National Association and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on June 4, 2021).

(m) 364-Day $1.5 Billion Revolving Credit Agreement, dated as of June 4, 2021, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent and as CAF Loan Agent, Bank of America, N.A. and Goldman Sachs Bank USA as Syndication Agents, Citibank, N.A., PNC Capital Markets LLC, National Association, U.S. Bank, National Association and Wells Fargo Securities, LLC, as Documentation Agents, and JPMorgan Chase Bank, N.A., BofA Securities, Inc., Goldman Sachs Bank USA, Citibank N.A., PNC Capital Markets LLC, U.S. Bank, National Association and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on June 4, 2021).

(n) $2.0 Billion Term Loan Credit Agreement, dated as of October 29, 2021, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent, Bank of America, N.A., as Syndication Agent, PNC Capital Markets LLC, U.S. Bank, National Association, Wells Fargo Securities, LLC, Citibank, N.A., and Truist Bank, as Documentation Agents, and JPMorgan Chase Bank, N.A., BofA Securities, Inc., PNC Capital Markets LLC, U.S. Bank, National Association, Wells Fargo Securities, LLC, Citibank, N.A., and Truist Securities, Inc., as Joint Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2021).

(o)	$500 Million Delayed Draw Term Loan Credit Agreement, dated as of May 28, 2021, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent, Bank of America, N.A. and Goldman Sachs Bank USA as Syndication Agents, Citibank, N.A., PNC Capital Markets LLC, U.S. Bank, National Association and Wells Fargo Securities, LLC, as Documentation Agents, and Goldman Sachs Bank USA, BofA Securities, Inc., JPMorgan Chase Bank, N.A., Citibank, N.A., PNC Capital Markets LLC, U.S. Bank, National Association and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on June 4, 2021).
(p)	Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(q)	Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(r)	Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(s)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(t)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(u)	Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(v)	Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005, File No. 001-05975).
(w)*	Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).
(x)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(y)*	Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).
(z)*	Amendment No. 2, dated as of August 16, 2018, to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated as of February 27, 2014 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.s Current Report on Form 8-K, filed on August 20, 2018).
(aa)*	Humana Inc. Change in Control Policy, effective March 1, 2019 (incorporated herein by reference to Exhibit 10(aa) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(bb)	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 7, 2014).

(cc)	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(dd)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(ee)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(gg) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(ff)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(hh) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(gg)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10(ii) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(hh)*	Humana Inc. Compensation Recoupment Policy, effective February 21, 2019 (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).
(ii)*	Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 18, 2019).
(jj)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(kk)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(ll)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(mm)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(nn)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019).
(oo)*	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (Non-Qualified Stock Options) (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2020).

(pp)*	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10(oo) to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2020).
(qq)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (incorporated herein by reference to Exhibit 10(pp) to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2020).
(rr)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(qq) to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2020).
(ss)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(rr) to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2020).
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).
31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.

101 The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in iXBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2021 and 2020; (ii) the Consolidated Statements of Income for the years ended December 31, 2021, 2020 and 2019; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2021, 2020 and 2019; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2021, 2020, and 2019; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2021, 2020 and 2019; and (vi) Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.

104 Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.

*Exhibits 10(a) through and including 10(k), and Exhibits 10(w) through and including 10(aa), as well as Exhibits 10(cc) through and including Exhibit 10(ss) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Exchange Act, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2021	2020
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 906	$ 436
Investment securities	428	336
Receivable from operating subsidiaries	1,316	1,187
Other current assets	545	763
Total current assets	3,195	2,722
Property and equipment, net	2,223	1,774
Investments in subsidiaries	26,885	17,005
Equity method investment	52	1,147
Long-term investment securities	207	836
Other long-term assets	407	686
Total assets	$ 32,969	$ 24,170
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 2,056	$ 1,342
Current portion of notes payable to operating subsidiaries	36	36
Book overdraft	68	120
Short-term debt	1,953	600
Other current liabilities	1,460	1,438
Total current liabilities	5,573	3,536
Long-term debt	10,541	6,060
Other long-term liabilities	775	846
Total liabilities	16,889	10,442
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,648,742 shares issued at December 31, 2021 and December 31, 2020	33	33
Capital in excess of par value	3,082	2,705
Retained earnings	23,086	20,517
Accumulated other comprehensive income (loss)	42	391
Treasury stock, at cost, 69,846,758 shares at December 31, 2021 and 69,787,914 shares at December 31, 2020	(10,163)	(9,918)
Total stockholders' equity	16,080	13,728
Total liabilities and stockholders' equity	$ 32,969	$ 24,170

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2021	2020	2019
	(in millions)		
Revenues:			
Management fees charged to operating subsidiaries	$ 1,633	$ 2,216	$ 1,789
Investment and other (loss) income, net	(266)	763	28
	1,367	2,979	1,817
Expenses:			
Operating costs	1,404	2,204	1,577
Depreciation	488	397	387
Interest	313	283	242
	2,205	2,884	2,206
Other (income) expense, net	(672)	60	(506)
(Loss) income before income taxes and equity in net earnings of subsidiaries	(166)	35	117
(Benefit) provision for income taxes	(259)	18	27
Income before equity in net earnings of subsidiaries	93	17	90
Equity in net earnings of subsidiaries	2,761	3,269	2,603
Equity in net earnings of Kindred at Home	79	81	14
Net income	$ 2,933	$ 3,367	$ 2,707

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2021	2020	2019
	(in millions)		
Net income attributable to Humana	$ 2,933	$ 3,367	$ 2,707
Other comprehensive income (loss):			
Change in gross unrealized investment (losses) gains	(356)	393	450
Effect of income taxes	81	(89)	(105)
Total change in unrealized investment (losses) gains, net of tax	(275)	304	345
Reclassification adjustment for net realized gains included in investment income	(103)	(90)	(34)
Effect of income taxes	23	20	8
Total reclassification adjustment, net of tax	(80)	(70)	(26)
Other comprehensive (loss) income, net of tax	(355)	234	319
Comprehensive income (loss) attributable to our equity method investment in Kindred at Home	6	1	(4)
Comprehensive income	$ 2,584	$ 3,602	$ 3,022

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2021	2020	2019
	(in millions)		
Net cash provided by operating activities	$ 2,853	$ 2,531	$ 3,529
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(4,187)	(709)	—
Capital contributions to operating subsidiaries	(2,580)	(538)	(423)
Purchases of investment securities	(200)	(460)	(204)
Proceeds from sale of investment securities	71	13	15
Maturities of investment securities	122	411	134
Purchases of property and equipment, net	(958)	(785)	(585)
Net cash used in investing activities	(7,732)	(2,068)	(1,063)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	2,953	1,088	987
Repayment of senior notes	—	(400)	(400)
Proceeds (repayments) from issuance of commercial paper, net	352	295	(360)
Proceeds from term loan	2,500	1,000	—
Repayment of term loan	—	(1,000)	(650)
Change in book overdraft	(52)	80	2
Common stock repurchases	(79)	(1,820)	(1,070)
Dividends paid	(354)	(323)	(291)
Proceeds from stock option exercises and other	29	47	57
Net cash provided by (used in) financing activities	5,349	(1,033)	(1,725)
Increase (decrease) in cash and cash equivalents	470	(570)	741
Cash and cash equivalents at beginning of year	436	1,006	265
Cash and cash equivalents at end of year	$ 906	$ 436	$ 1,006

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $1.6 billion in 2021, $1.3 billion in 2020, and $1.8 billion in 2019.

Guarantee

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

3. REGULATORY REQUIREMENTS

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurance subsidiaries had aggregate statutory capital and surplus of approximately $9.6 billion and $9.4 billion as of December 31, 2021 and 2020, respectively, which exceeded aggregate minimum regulatory requirements of $7.6 billion and $7.0 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2022 is approximately $1.5 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $1.6 billion in 2021, $1.3 billion in 2020, and $1.8 billion in 2019.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions. During 2021, 2020 and 2019, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 13 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDERS' EQUITY

Refer to Note 16 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2021, 2020, and 2019
(in millions)

		Additions			
	Balance at Beginning of Period	Charged (Credited) to Costs and Expenses	Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:					
2021	$ 72	$ 21	$ (3)	$ (7)	$ 83
2020	69	36	(1)	(32)	72
2019	79	(1)	—	(9)	69
Deferred tax asset valuation allowance:					
2021	(37)	(28)	—	—	(65)
2020	(45)	8	—	—	(37)
2019	(54)	9	—	—	(45)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.	
By:	/s/ SUSAN M. DIAMOND
	Susan M. Diamond **Chief Financial Officer** **(Principal Financial Officer)**
Date:	February 17, 2022

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ SUSAN M. DIAMOND **Susan M. Diamond**	Chief Financial Officer (Principal Financial Officer)	February 17, 2022
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Senior Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)	February 17, 2022
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 17, 2022
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 17, 2022
/s/ RAQUEL C. BONO, M.D. **Raquel C. Bono, M.D.**	Director	February 17, 2022
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 17, 2022
/s/ WAYNE A. I. FREDERICK, M.D. **Wayne A. I. Frederick, M.D.**	Director	February 17, 2022
/s/ JOHN W. GARRATT **John W. Garratt**	Director	February 17, 2022
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 17, 2022
/s/ KAREN W. KATZ **Karen W. Katz**	Director	February 17, 2022
/s/ MARCY S. KLEVORN **Marcy S. Klevorn**	Director	February 17, 2022
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 17, 2022
/s/ JORGE S. MESQUITA **Jorge S. Mesquita**	Director	February 17, 2022
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 17, 2022
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 17, 2022

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ALABAMA
Horizon Health Network LLC
Mid-South Home Care Services, LLC
Mid-South Home Health Agency, LLC
Wiregrass Hospice LLC

ARIZONA
Central Arizona Home Health Care, Inc.

ARKANSAS
Humana Regional Health Plan, Inc.

CALIFORNIA
Asian American Home Care, Inc.
Humana EAP and Work-Life Services of California, Inc.
Humana Health Plan of California, Inc.
Professional Healthcare at Home, LLC

COLORADO
Alpine Home Health Care, LLC
Legacy Hospice of Colorado Springs, LLC
Legacy Hospice, LLC

DELAWARE
Access Home Health of Florida, LLC
Amazing Home Health Holdings, LLC
American Homecare Management Corp.
Avalon Hospice Iowa, LLC
Avalon Hospice Minnesota, LLC
Avalon Hospice Missouri, LLC
Avalon Hospice Nebraska, LLC
Avalon Hospice Ohio, LLC
Avalon Hospice Pennsylvania, LLC
Bethany Hospice, LLC
CDO 1, LLC
CDO 2, LLC
Carrolton Home Care, LLC
Cedar Valley Hospice, LLC
CenterWell Care Solutions, Inc.
CH Services Group Holdings, Inc.
CH Services Holdings, Inc.
CH Services Midco Holdings, Inc.
Charlotte Buyer, Inc.
Community Home Care & Hospice, LLC
Community Home Care of Robeson County, LLC
Community Home Care of Vance County, LLC
Community Hospice of The Carolinas, LLC
Community Hospice, LLC
CompBenefits Corporation
CompBenefits Direct, Inc.
Conviva Care Solutions, LLC
Conviva Care Solutions II, LLC
Conviva Group Holdings, LLC
Conviva Health Management, LLC

Conviva Health MSO of Texas, Inc.
Conviva Medical Center Management, LLC
CTW Development, LLC
Curo Arizona Hospice, LLC
Curo Community Hospice, LLC
Curo Health Services Holdings, Inc.
Curo Health Services, LLC
Curo Hospice SC, LLC
Curo Houston Hospice, LLC
Curo Texas Holdings, LLC
Curo Texas Hospice, LLC
Curo Utah Home Care, Inc.
Curo Utah Hospice, Inc.
Eagle NY Rx, LLC
Eagle Rx Holdco, Inc.
Eagle Rx, Inc.
Echo Primary Care Holdings, LLC
Edge Health MSO, Inc.
Emphesys, Inc.
Enclara Pharmacia, Inc.
FHI Health Systems, Inc.
FPG Acquisition Corp.
FPG Acquisition Holdings Corp.
FPG Holding Company, LLC
Gentiva Certified Healthcare Corp.
Gentiva Health Services (Certified), Inc.
Gentiva Health Services (USA) LLC
Gentiva Health Services Holding Corp.
Gentiva Health Services, Inc.
Go365, LLC
Harden Healthcare Holdings, LLC
Harden Home Health, LLC
Health Value Management, Inc.
Healthfield Operating Group, LLC
Healthfield, LLC
Heritage Health And Hospice Care, LLC
HHS Healthcare Corp.
Hospice Development Company 2, LLC
Hospice Development Company 3, LLC
Hospice Family Care, Inc.
Hospice of Colorado, LLC
Hospice of Connecticut, LLC
Hospice of Maine, LLC
Hospice of Mesilla Valley, LLC
Hospice of Minnesota, LLC
Hospice of Texas, LLC
HUM Provider Holdings, LLC
Humana at Home, Inc.
Humana Digital Health and Analytics Platform Services, Inc.
Humana Direct Contracting Entity, Inc.
Humana Government Business, Inc.
Humana Inc.
Humana Innovation Enterprises, Inc.
Humana Pharmacy, Inc.
Humana WellWorks LLC
HumanaDental, Inc.
Integracare Holdings, Inc.
Integracare Intermediate Holdings, Inc.
International Tutoring Services, LLC

KAH Development 10, L.L.C.
KAH Development 12, L.L.C.
KAH Development 14, L.L.C.
KAH Development 4, L.L.C.
KAH Development 8, L.L.C.
KAH Hospice Company, Inc.
Kentucky Homecare Holdings, Inc.
Kentucky Homecare Parent Inc.
Kindred Hospice Missouri, LLC
Kindred Hospice Services, L.L.C.
KND Development 50, L.L.C.
KSOC Holdings, Inc.
Lifepath Hospice and Family Care, L.L.C.
Mid-South Home Health, LLC
New Beacon Healthcare Group, LLC
New Beacon Healthcare Indiana, LLC
New Beacon Hospice Indiana, LLC
New Century Hospice Delaware, LLC
New Century Hospice of Richmond, LLC
New Century Hospice Texas, LLC
New Century Hospice Virginia, LLC
New Century Hospice, Inc.
North Region Providers, LLC
NP Plus, LLC
Odyssey Healthcare GP, LLC
Odyssey Healthcare Holding Company
Odyssey Healthcare LP, LLC
Odyssey Healthcare Management, LP
Odyssey Healthcare of Augusta, LLC
Odyssey Healthcare of Flint, LLC
Odyssey Healthcare of Kansas City, LLC
Odyssey Healthcare of Marion County, LLC
Odyssey Healthcare of Savannah, LLC
Odyssey Healthcare of South Texas, LLC
Odyssey Healthcare Operating A, LP
Odyssey Healthcare Operating B, LP
Odyssey Healthcare, Inc.
One Home Medical Equipment NC, LLC
One Home Medical Equipment VA, LLC
One Infusion Pharmacy NC, LLC
One Infusion Pharmacy VA, LLC
PBM Holding Company
PBM Plus Mail Service Pharmacy, LLC
Peoplefirst Homecare & Hospice of Indiana, L.L.C.
Peoplefirst Homecare & Hospice of Massachusetts, L.L.C.
Peoplefirst Homecare & Hospice of Ohio, L.L.C.
Peoplefirst Homecare of Colorado, L.L.C.
PF Development 10, L.L.C.
PF Development 15, L.L.C.
PF Development 16, L.L.C.
PF Development 21, L.L.C.
PF Development 23, L.L.C.
PF Development 5, L.L.C.
PF Development 7, L.L.C.
PF Development 9, L.L.C.
Pharaoh JV, LLC
PHH Acquisition Corp.
PHHC Acquisition Corp.
Primary Care Holdings II, LLC

Professional Healthcare, LLC
Regency Healthcare Group, LLC
Regency Healthcare Holdings, LLC
Regency Home Office, LLC
Regency Hospice of Georgia, LLC
Regency Hospice of Northwest Florida, Inc.
Regency Southerncare Hospice, LLC
SHC Holding, Inc.
Southerncare Holdings, Inc.
Southerncare, Inc.
Sun Brook Hospice, LLC
TNMO Healthcare, LLC
Transcend Population Health Management II, LLC
Vista Hospice Care, LLC
Vistacare of Boston, LLC
Vistacare USA, LLC
Vistacare, LLC
Voyager Home Health, Inc.
Voyager Hospicecare, Inc.

DOMINICAN REPUBLIC
Trueshore S.R. I.

FLORIDA
Advanced Oncology Services, Inc.
Amazing Home Health Care, Inc.
Care Hope Holdings, Inc.
Care Hope Home Health Agency, Inc.
Care Partners Home Care, LLC
CarePlus Health Plans, Inc.
CenterWell Senior Primary Care (FL), Inc.
CompBenefits Company
Complex Clinical Management, Inc.
Conviva Physician Group, LLC
Conviva Specialty, LLC
Elite Health Medical Centers, LLC
Elite Health Primary Care, LLC
Enhanz DCE, LLC
FPG Senior Services, LLC
Homecare Holdings, Inc.
Hospice of the Emerald Coast, Inc.
HUM-e-FL, Inc.
Humana At Home 1, Inc.
Humana Dental Company
Humana Health Insurance Company of Florida, Inc.
Humana Medical Plan, Inc.
Med. Tech. Services of South Florida, Inc.
Med-Tech Services of Dade, Inc.
Med-Tech Services of Palm Beach, Inc.
METCARE of Florida, Inc.
Metropolitan Health Networks, Inc.
Naples Health Care Specialists, LLC
Nursing Solutions, LLC
On the Way Home Care, Inc.
One Home Health Holdings, LLC
One Home Medical Equipment, LLC
One Homecare Solutions, LLC
One Homecare Systems, LLC

One Infusion Pharmacy, LLC
One Nursing Care, LLC
One TPA Systems, Inc.
SeniorBridge Family Companies (FL), Inc.
SeniorBridge-Florida, LLC
Senior Home Care, Inc.
South Florida Cardiology Associates, LLC
Trueshore BPO, LLC

GEORGIA
At Home Healthcare And Hospice, LLC
At Home Hospice of Alpharetta, LLC
Capital Care Resources of South Carolina, LLC
Capital Care Resources, LLC
Capital Health Management Group, LLC
Chattahoochee Valley Home Care Services, LLC
Chattahoochee Valley Home Health, LLC
CHMG Acquisition LLC
CHMG of Atlanta, LLC
CHMG of Griffin, LLC
Healthfield Home Health, LLC
Healthfield Hospice Services, LLC
Healthfield of Southwest Georgia, LLC
Healthfield of Statesboro, LLC
Healthfield of Tennessee, LLC
Humana Employers Health Plan of Georgia, Inc.
Kindred at Home Foundation, Inc.
Mid-South Home Health of Gadsden, LLC
Total Care Home Health of Louisburg, LLC
Total Care Home Health of North Carolina, LLC
Total Care Home Health of South Carolina, LLC
Wiregrass Hospice Care, LLC
Wiregrass Hospice of South Carolina, LLC

ILLINOIS
CompBenefits Dental, Inc.
Dental Care Plus Management, Corp.
Humana Benefit Plan of Illinois, Inc.
Humana Healthcare Research, Inc.
Loving Peace Hospice, Inc.
Medical Advocate Healthcare Services Corporation

INDIANA
SeniorBridge Family Companies (IN), Inc.

IOWA
Hawkeye Health Services, Inc.
Iowa Hospice, L.L.C.

KANSAS
Hospice Care of Kansas, L.L.C.
The Home Team of Kansas LLC

KENTUCKY
516-526 West Main Street Condominium Council of Co-Owners, Inc.
CHA HMO, Inc.
Humana Active Outlook, Inc.

Humana Health Plan, Inc.
Humana Insurance Company of Kentucky
Humana MarketPOINT, Inc.
Humana Pharmacy Solutions, Inc.
Humana Real Estate Company
Humco, Inc.
The Dental Concern, Inc.

LOUISIANA
Generations Hospice Service Corporation
Humana Health Benefit Plan of Louisiana, Inc.
Synergy Home Care-Acadiana Region, Inc.
Synergy Home Care-Capitol Region, Inc.
Synergy Home Care-Central Region, Inc.
Synergy Home Care-Northeastern Region, Inc.
Synergy Home Care-Northshore Region, Inc.
Synergy Home Care-Northwestern Region, Inc.
Synergy Home Care-Southeastern Region, Inc.
Synergy, Inc.

MICHIGAN
Humana Medical Plan of Michigan, Inc.

MISSISSIPPI
Gilbert's Home Health Agency, Inc.
Gilbert's Hospice Care, LLC
Home Health Care Affiliates of Central Mississippi, L.L.C.
Home Health Care Affiliates of Mississippi, Inc.
Home Health Care Affiliates, Inc.
Van Winkle Home Health Care, Inc.

MISSOURI
Missouri Home Care of Rolla, Inc.
The American Heartland Hospice Corp.

NEVADA
FHI LP, Inc.
Southern Nevada Home Health Care, Inc.

NEW YORK
Alexander Infusion, LLC
Gentiva Services of New York, Inc.
Harris, Rothenberg International Inc.
Humana Health Company of New York, Inc.
Humana Insurance Company of New York
New York Healthcare Services, Inc.
SeniorBridge Family Companies (NY), Inc.
QC-Medi New York, Inc.
Quality Care - USA, Inc.

OHIO
Humana Health Plan of Ohio, Inc.
Hummingbird Coaching Systems LLC

OKLAHOMA
Freedom Hospice, LLC

PENNSYLVANIA
Humana Medical Plan of Pennsylvania, Inc.

PUERTO RICO
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance of Puerto Rico, Inc.
Humana Management Services of Puerto Rico, Inc.
Humana MarketPOINT of Puerto Rico, Inc.

SOUTH CAROLINA
Humana Benefit Plan of South Carolina, Inc.

TENNESSEE
Cariten Health Plan Inc.
Freedom Hospice, LLC
PHP Companies, Inc.
Preferred Health Partnership, Inc.

TEXAS
ABC Hospice, LLC
Aberdeen Holdings, Inc.
Able Home Healthcare, Inc.
American Hospice, Inc.
Angel Heart Hospice, LLC
BWB Sunbelt Home Health Services, LLC
California Hospice, LLC
Compass Hospice, Inc.
CompBenefits Insurance Company
Corpus Christi Home Care, Inc.
Cosmos Hospice of Corpus Christi, LLC
Cosmos Hospice of San Antonio, LLC
DentiCare, Inc.
Emphesys Insurance Company
Family Hospice, Ltd.
FHI GP, Inc.
FHI Management, Ltd.
Focus Care Health Resources, Inc.
GBA Holding, Inc.
GBA West, LLC
Georgia Hospice, LLC
Girling Health Care, Inc.
Harden Clinical Services, LLC
Harden HC Texas Holdco, LLC
Harden Healthcare, LLC
Harden Hospice, LLC
Home Health of Rural Texas, Inc.
Horizon Health Care Services, Inc.
Humana At Home (Dallas), Inc.
Humana At Home (Houston), Inc.
Humana At Home (San Antonio), Inc.
Humana At Home (TLC), Inc.
Humana Benefit Plan of Texas, Inc.
Humana Health Plan of Texas, Inc.
Integracare Home Health Services, Inc.
Integracare Hospice of Abilene, LLC
Integracare of Abilene, LLC
Integracare of Albany, LLC
Integracare of Athens-Home Health, LLC

Integracare of Athens-Hospice, LLC
Integracare of Olney Home Health, LLC
Integracare of Texas, LLC
Integracare of West Texas-Home Health, LLC
Integracare of West Texas-Hospice, LLC
Integracare of Wichita Falls, LLC
Lighthouse Hospice - Coastal Bend, LLC
Lighthouse Hospice - Metroplex, LLC
Lighthouse Hospice Management, LLC
Lighthouse Hospice-San Antonio, LLC
OHS Service Corp.
One Home Health Holdings CCTX, LLC
One Home Medical Equipment TX, LLC
Outreach Health Services of North Texas, LLC
ROHC, L.L.C.
Texas Dental Plans, Inc.
Trinity Hospice of Texas, LLC
Vernon Home Health Care Agency, LLC
Voyager Acquisition, L.P.

UTAH
Home Health Services, Inc.
Humana Medical Plan of Utah, Inc.

VERMONT
Managed Care Indemnity, Inc.

WASHINGTON
Arcadian Health Plan, Inc.

WEST VIRGINIA
First Home Health, Inc.
Nursing Care-Home Health Agency, Inc.

WISCONSIN
CareNetwork, Inc.
GuidantRx, Inc.
Humana Insurance Company
Humana Wisconsin Health Organization Insurance Corporation
HumanaDental Insurance Company
Independent Care Health Plan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 033-49305, 333-04435, 333-57095, 333-86801, 333-41408, 333-86280, 333-105622, 333-134887, 333-162747, 333-171616, 333-175350, and 333-231154) and S-3 (No. 333-254041) of Humana Inc. of our report dated February 17, 2022 relating to the financial statements and financial statement schedules and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

February 17, 2022

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Bruce D. Broussard, principal executive officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date:	February 17, 2022
Signature:	/s/ BRUCE D. BROUSSARD
	Bruce D. Broussard Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Susan M. Diamond, principal financial officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date:	February 17, 2022
Signature:	/s/ SUSAN M. DIAMOND
	Susan M. Diamond Principal Financial Officer

Exhibit 32

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Humana Inc. (the “Company”) on Form 10-K for the period ended December 31, 2021 as filed with the Securities and Exchange Commission on the date hereof (the “Report”), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ BRUCE D. BROUSSARD

Bruce D. Broussard
President and Chief Executive Officer
(Principal Executive Officer)

February 17, 2022

/s/ SUSAN M. DIAMOND

Susan M. Diamond
Chief Financial Officer
(Principal Financial Officer)

February 17, 2022

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.