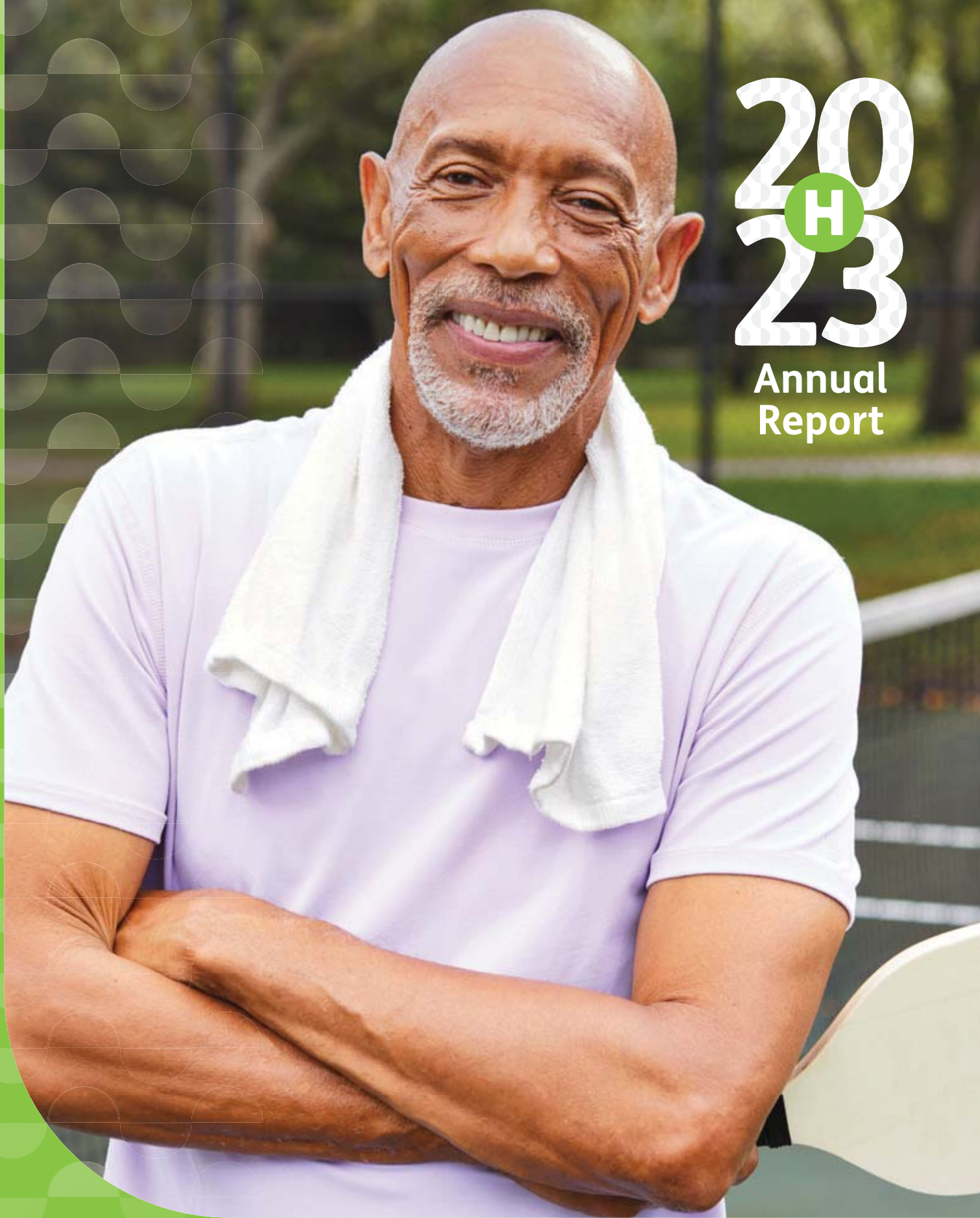


2023 Annual Report

Humana®

Humana Inc. financial highlights

Dollars in millions, except per common share results

Generally Accepted Accounting Principles (GAAP)	2023	2022	2021	2020	2019
OPERATING RESULTS					
Revenues	**$106,374**	$92,870	$83,064	$77,155	$64,888
Net income attributable to Humana	**$2,489**	$2,806	$2,933	$3,367	$2,707
Diluted earnings per common share	**$20.00**	$22.08	$22.67	$25.31	$20.10
FINANCIAL POSITION					
Total assets	**$47,065**	$43,055	$44,358	$34,969	$29,074
Total liabilities	**$30,747**	$27,685	$28,255	$21,241	$17,037
Total stockholders' equity	**$16,318**	$15,370	$16,103	$13,728	$12,037
Cash flows from operations	**$3,981**	$4,587	$2,262	$5,639	$5,284
MEMBERSHIP (IN THOUSANDS)					
Consolidated medical membership	**16,857.8**	17,079.2	17,067.0	16,831.6	16,667.2
Consolidated specialty membership	**4,868.3**	5,194.8	5,294.3	5,310.3	5,425.9

Dear fellow stockholders,

2023 was a dynamic and challenging year as the Medicare Advantage (MA) industry faced a significant and unanticipated increase in medical cost trends throughout the year. We worked hard to offset the higher than anticipated medical costs through areas such as administrative cost containment and productivity initiatives, as well as other business outperformance. We take our commitments seriously and are disappointed we were unable to fully offset the further increase in cost trends experienced in the fourth quarter, despite our best efforts to identify mitigation opportunities throughout the year, resulting in lower than anticipated earnings growth for 2023.

While not minimizing the significance of those challenges, we are proud of the strong growth we achieved in our individual MA, Medicaid and CenterWell™ businesses and the progress made across the enterprise to advance our industry-leading MA and senior-focused value-based care platforms, supported by the unwavering commitment of our over 67,000 teammates.

We are proud of the strong growth we achieved in our individual MA, Medicaid and CenterWell businesses.

BRUCE BROUSSARD
Chief Executive Officer
and Board Member

KURT HILZINGER
Chairman of
the Board

Business update

Our shift over the years from a health insurance company to a healthcare services organization symbolizes more than a strategic evolution; it represents our dedication and commitment to caring for the needs of our customers and patients, our employees, our communities and our environment.

For our customers and patients, it is our responsibility to ensure they receive the high-quality, comprehensive care they deserve.

Medicare Advantage

In our individual MA business, **we were pleased to grow membership by over 840,000** in 2023, representing an impressive 19% growth rate, significantly outpacing the industry. We're proud that our dedication to putting our members' health first was recognized again this year in our Centers for Medicare & Medicaid Services (CMS) Star Ratings, with **94% of our members in plans rated 4 stars or higher**, 61% in plans rated 4.5 or 5 stars, and 37% of all 5-star MA membership in a Humana plan. In addition, for the third year in a row, Humana has been ranked No. 1 among health insurers for customer experience quality in Forrester's proprietary 2023 U.S. Customer Experience Benchmark survey. Humana also ranked No. 1 in customer satisfaction among MA plans in Florida based on a comprehensive 2023 study by J.D. Power, and we are proud that Humana has once again been named the Best Overall Medicare Advantage Insurance Company by U.S. News & World Report, which created an honor roll based on CMS's newly released Star Ratings for MA plans. Additionally, Humana ranked as the best company for member experience and was declared the best company for low-premium plan availability. Collectively, these ratings demonstrate our continued commitment to customer satisfaction and quality of care.

While the elevated MA medical costs impacting the industry significantly influenced our financial results for 2023 and outlook for 2024, we continue to believe the strong fundamentals of MA remain intact and the strength and scale of our platform and differentiated capabilities will allow us to effectively manage through the near-term uncertainty, compete effectively and deliver compelling shareholder returns over the long term.

We believe the value proposition of MA will remain compelling

Today, more than half of all Medicare-eligible seniors and those with disabilities rely on MA—more than 32 million Americans.[1] These beneficiaries choose MA because it delivers the accountable, high-quality, consumer-centric healthcare they depend on. In a time when MA is facing near-term challenges, we believe it is important to reinforce our belief that MA has strong industry fundamentals and secular growth prospects due to an aging population and a value proposition that will continue to be superior to fee-for-service Medicare.

The average MA enrollee is more likely, as compared to those with fee-for-service Medicare, to live on less than $20,000 per year.[2] That underscores why MA is deeply valued and relied on by millions of seniors. MA provides a significant value proposition: providing on-average cost savings for an enrollee of $2,400 per year;[3] offering key benefits that are not covered by fee-for-service Medicare, such as access to healthy foods and rides to the doctor; and a deep focus on coordinating care for those with chronic illnesses and closing barriers to care. Seniors choosing MA have doubled since 2010, moving from 25% in 2010 to 54% currently, demonstrating the strong value proposition enrollees see in MA being right for their health needs.[4,5] As we look ahead, the Medicare population will continue to grow. Kaiser Family Foundation anticipates there will be **70 million Medicare-eligible Americans by 2030**, with MA penetration rates greater than 60%.[6,4]

In addition, the MA program has embedded adjusting mechanisms—including CMS benchmarks, risk adjustment and the ability to re-price each year—which enable Humana and others in the industry to adequately address unanticipated increases in medical costs within a relatively short period of time. Importantly, while moderate benefit adjustments will cause disruption for members in the near term, which the industry in its partnership with CMS must manage, we believe the value proposition of MA will remain compelling. As a result, we continue to expect the industry to experience high single-digit growth in the mid-term, including 2024.

94%

of our MA members in plans rated 4 stars or higher

25% → 54%

Seniors choosing MA have doubled since 2010

Medicaid

In our Medicaid business, Humana continues to demonstrate the ability to deliver unique value to communities by building on a strong operating model that integrates physical and behavioral health and develops meaningful partnerships and innovations to address health inequities and social determinants of health. After successfully implementing the Ohio and Louisiana contracts in early 2023, we look forward to beginning to serve members in both Indiana and Oklahoma in 2024 and continue to expect to bring our total Medicaid footprint to nine states and approximately 1.5 million members by year-end 2024.

We expect to bring our total Medicaid footprint to nine states and approximately 1.5 million members by year-end 2024

Access to care is a priority for all state Medicaid agencies, and as an example of our success, our Kentucky plan is performing above the 90th percentile for member satisfaction with receiving care easily.

We're significantly reducing hospital admissions and readmissions by increasing and enhancing preventive care. In 2023, our Florida Medicaid plan reduced preventable admissions by 22% and reduced readmissions by 11%. States want to see Medicaid managed care organizations empower elderly and disabled members to age in community settings; our Medicaid plans have successfully transitioned more than 5,000 members out of nursing homes since 2019. We see a path to continue a strong Medicaid growth trajectory through a **continued focus on connecting Humana's differentiating enterprise capabilities to state agency priorities and maintaining operational excellence** as we continue to manage significant growth.

Our Florida Medicaid plan

↓ 22%

reduced preventable hospital admissions

↓ 11%

reduced hospital readmissions

CenterWell healthcare services

We've designed our CenterWell healthcare services so they are integrated and accessible where, when, and how our customers need them. Through our CenterWell offerings of primary care, home health, and pharmacy, our members and patients experience better health outcomes and greater satisfaction and are more likely to continue their health journey with us.

Primary care

Our primary care business is designed to address the unique needs of seniors, providing access to care in historically underserved areas by improving access to primary care. Focused on delivering quality care and patient experiences, our clinics emphasize prevention and lifestyle changes to improve the overall health of our patients. We continue to push for improvement in our operations and our ability to positively impact patient outcomes. Our primary care platform experienced significant growth in 2023, now operating 296 centers serving over 294,000 patients, representing year-over-year growth of 26% and 19%, respectively. In addition, we increased the number of wholly owned centers that are contribution margin positive from 110 at the end of 2022 to 150 at year-end 2023, representing a 36% increase year over year.

Operating 296 centers serving over 294,000 patients

We also increased the number of centers that have reached our $3 million contribution margin target from 31 in 2022 to 53 at the end of 2023, representing a compelling 71% increase year over year. We will continue to expand our multi-payer primary care platform in 2024 as we expect to continue the growth pace that we have previously communicated: between 30 to 50 incremental centers annually. From a patient outcome perspective, we are pleased to share that 95% of physician patient panels had a primary care provider visit and 92% of the total panel had a preventive screening in 2023. Patient satisfaction scores continue to reflect the quality of care delivered, with Net Promoter Scores averaging +83.4 nationally. In addition, we are proud of our quality scores; we have closed 85% of all available Healthcare Effectiveness Data and Information Set (HEDIS®) gaps for our MA patients across our wholly owned and de novo centers, delivering a **4.5-star rating in 2023 for our patients.**

Home health

In the home, we continue to expand our value-based home care models, now **covering 843,500 of our MA members under a value-based payment model** covering home health, durable medical equipment (DME) and infusion services. In addition, during 2024, we anticipate launching our home health utilization management services in additional states, increasing the share of Humana MA membership covered by approximately 13% to 3.4 million by year-end.

Covering 843,500 of our MA members under a value-based payment model

In 2023 we launched our first value-based home healthcare model in partnership between CenterWell Home Health® and CenterWell Senior Primary Care®. For 25,000 members in Central North Florida, this contractual model enables **clinical innovation in the form of tighter connection between primary care and the home health provider.** Each patient's care plan begins with a pre-visit clinical screening, optimized interventions for their clinical needs, a feedback loop with their primary care provider and supplemental visits for additional support when needed. This close connectivity to the primary care provider also allows the home health team to quickly adjust to changing needs during the episode of care. In 2024 we will expand this model to a broader population and further refine the operational and technological enhancements that can further reduce the total cost of care.

Within CenterWell Home Health, we are proud that greater than 50% of the more than 350 locations in 38 states achieved a Star Rating of 4.5 or above, up from 29% in July 2022, with clinicians making thousands of home visits each day and serving 380,000 patients annually. Additionally, CenterWell Home Health branches received a 4.29 average Quality of Patient Care rating from CMS in 2023, outperforming the CMS industry average of 3.25.

Greater than 50%

of the more than 350 locations in 38 states achieved a Star Rating of 4.5 or above

4.29

average Quality of Patient Care rating from CMS in 2023

2.6 million customers served

Pharmacy

In our pharmacy business, our mail-order rate is among the top in the country, with a 35% penetration of individual MA members. CenterWell Pharmacy® served over 2.6 million customers and filled nearly 51.5 million mail-order pharmacy prescriptions in 2023. We've made it easier to manage and fill prescriptions through a variety of ways.

As an example, we have been focused on investments in our digital channels and have seen a greater than 800 basis point increase in scripts received through these channels in 2023, now representing approximately 39% of total scripts, with early data showing continuing positive momentum in 2024.

Nearly

51.5 million

mail-order pharmacy prescriptions filled

Increased use of digital channels provides an efficient and user-friendly experience for patients, allowing for real-time formulary adjudication and the ability to offer cost-saving alternatives in real time—while also driving operational efficiencies for Humana.

In addition, we continue to advance our clinical capabilities and were proud to achieve **250 to 290 basis point better medication adherence** compared to non-CenterWell Pharmacy patients, reducing average medical costs by more than $400 annually.

Better medication adherence reduced average medical costs by

$400+ each year

compared to non-CenterWell Pharmacy patients

We are committed to improving healthcare access and health outcomes through

health equity efforts

Environmental, social and governance

For our employees

For our employees, we strive to create a workforce that mirrors the diversity and resilience of the communities we serve. Part of this commitment is reflected in the learning programs and training/development opportunities we offer that support our teammates' health, sense of belonging, purpose, and security. Our efforts were recognized as a DiversityInc Top Employer for Diversity and as a Certified Great Place to Work®.

For our communities

For our communities, we are committed to improving healthcare access and health outcomes through health equity efforts. In fact, the results of a study of over 500,000 Humana MA members in 2021 showed patients of value-based, senior-focused primary care organizations (like CenterWell Senior Primary Care) had more primary care visits, fewer hospitalizations and fewer emergency department visits than patients of more traditional primary care providers.

The largest differences were seen among Black patients, who received 49% more primary care visits, 22% fewer emergency department visits and 16% fewer hospitalizations.

We launched health literacy, cultural humility and implicit bias training for employees to better understand, support and care for the diverse needs of our patients and members.

Through Humana Healthy Horizons®, our Medicaid brand, we've contributed $10 million in community investments to support and fund equity-focused programs and community organizations.

We're also breaking down barriers for veterans by providing access to meals and addressing homelessness—each in partnership with the Humana Foundation, which donated 23 grants totaling $12.9 million to communities in 2023.

Committed to reducing greenhouse gas emissions

54.6%

by 2032

For our environment

For our environment, just as we care about our customers and our employees, we are also committed to the health of our planet. We are committed to reducing greenhouse gas emissions 54.6% by 2032 from a 2019 base year. We are pleased that the Science Based Targets initiative (SBTi) has designated Humana as a Business Ambition for 1.5°C company and approved our science-based target. Among other strategies, our science-based target to reduce Scope 1 and Scope 2 greenhouse gas emissions includes continued investment and improvements to achieve energy-efficient buildings, transitioning our fleet and procurement of renewable energy. We will also address the approved Scope 3 target by engaging, educating and partnering with suppliers to set their own science-based targets. Our environmental and sustainability efforts are rooted in science and designed to make a positive impact on climate change, pollution and other environmental factors that impact health.

Conclusion

While 2023 was a challenging year, we made significant progress advancing our integrated care delivery strategy. We believe the strong fundamentals of MA remain intact, and the strength and scale of our platform and differentiated capabilities will allow us to effectively manage through the near-term uncertainty, compete effectively and deliver compelling shareholder returns over the long term.

JIM RECHTIN
President and Chief Operating Officer

Finally, we are thrilled that Jim Rechtin joined Humana on Jan. 8, 2024, as President and Chief Operating Officer. Jim brings a strong combination of operational, industry and CEO expertise, making him uniquely positioned to provide invaluable insight to the team as we navigate this dynamic time, and we are already seeing the benefits of his unique experience and skill set. Jim will work closely with Bruce and the team until the latter half of 2024, at which time Bruce will step down and Jim will assume the CEO role.

Humana's ongoing success and sustainability would not be possible without the trust and dedication of our many stakeholders, including our employees, our members and patients, our clinician partners, our governmental partners and our stockholders. **We thank each of you for your commitment to Humana and look forward to strengthening our partnership in the future as we continue our journey of providing better outcomes for our members and patients, while also driving compelling returns to our shareholders.**

The company has included an Adjusted EPS (earnings per share) financial measure herein that is not in accordance with GAAP. Management believes that this measure, when presented in conjunction with the corresponding GAAP measure, provides a comprehensive perspective to more accurately compare and analyze the company's core operating performance over time. Consequently, management uses this non-GAAP (Adjusted) financial measure as a consistent and uniform indicator of the company's core business operations from period to period, as well as for planning and decision-making purposes and in determination of incentive compensation. The non-GAAP (Adjusted) financial measure should be considered in addition to, but not as a substitute for, or superior to, the financial measure prepared in accordance with GAAP. All financial measures herein are in accordance with GAAP unless otherwise indicated.

Amortization associated with identifiable intangibles: Since amortization varies based on the size and timing of acquisition activity, management believes this exclusion provides a more consistent and uniform indicator of performance from period to period.

Put/call valuation adjustments associated with company's non-consolidating minority interest investments: These amounts are the result of the fair value measurements associated with the company's Primary Care Organization strategic partnership and are unrelated to the company's core business operations.

Transactions and integration costs: The transaction and integration costs primarily relate to the acquisition of Kindred at Home in 2021 and the subsequent divestiture of Gentiva (formerly Kindred) Hospice in 2022.

Change in fair value of publicly traded equity securities: These gains and losses are a result of market and economic conditions that are unrelated to the company's core business operations.

Diluted earnings per common share (EPS)

	FY 2023	FY 2022
GAAP RESULTS	**$20.00**	$22.08
Amortization associated with identifiable intangibles	**0.54**	0.64
Put/call valuation adjustments associated with company's non-consolidating minority interest investments	**2.57**	0.53
Transaction and integration costs	**(0.38)**	0.83
Change in fair market value of publicly traded equity securities	**(0.01)**	0.97
Impact of exit of employer group commercial medical products business	**0.13**	0.84
Accrued charge related to certain anticipated litigation expenses	**0.84**	-
Value creation initiatives	**3.50**	3.72
Impairment charges	**0.73**	-
Gain on the sale of Gentiva (formerly Kindred) Hospice	**-**	(1.86)
Cumulative net tax impact of non-GAAP adjustments	**(1.83)**	(1.87)
ADJUSTED (NON-GAAP)	**$26.09**	$25.88

Impact of exit of employer group commercial medical products business: Prior period segment financial information has been recast to exclude the impact of the exit of the employer group commercial medical products business as announced by Humana on February 23, 2023.

Accrued charge related to certain anticipated litigation expenses: This charge relates to certain anticipated expenses the company has accrued in connection with a legal matter.

Value creation initiative: These charges relate to the company's ongoing initiative to drive additional value for the enterprise through cost saving, productivity initiatives, and value creation from previous investments, and primarily consist of asset impairment and severance charges.

Impairment charges: The company recognized non-cash impairment charges in 4Q23 related to (1) certain indefinite-lived intangible assets based on the company's estimate of future financial performance in certain state markets and (2) investments in certain joint ventures for which the company held minority ownership interests that were deemed to be unrecoverable based on recent market activity.

Gain on sale of Gentiva (formerly Kindred) Hospice: Reflects the gain related to the sale of the company's 60% ownership of Gentiva (formerly Kindred) Hospice.

Cumulative net tax impact of non-GAAP adjustments: This adjustment represents the cumulative net impact of the corresponding tax benefit or expense related to the aforementioned items excluded from the applicable GAAP measures.

Thank you for your continued partnership and trust in Humana.

Sincerely,

Bruce D. Broussard
Chief Executive Officer
and Board Member
Humana Inc.

Kurt J. Hilzinger
Chairman of the Board
Humana Inc.

Humana Board of Directors

RAQUEL C. BONO, M.D.
Principal
RCB Consulting
Former Chief Health Officer
Viking Cruises

BRUCE D. BROUSSARD
Chief Executive Officer
Humana Inc.

FRANK A. D'AMELIO
Former Executive Vice President,
Chief Financial Officer
Pfizer Inc.

DAVID T. FEINBERG, M.D.
Chairman
Oracle Health

WAYNE A.I. FREDERICK, M.D., F.A.C.S.
President Emeritus
Howard University

JOHN W. GARRATT
Former President and
Chief Financial Officer
Dollar General Corporation

KURT J. HILZINGER
Chairman of the Board
Humana Inc.
Partner
Court Square Capital Partners, LP

KAREN W. KATZ
Former President and
Chief Executive Officer
Neiman Marcus Group LTD LLC

MARCY S. KLEVORN
Former Chief
Transformation Officer
Ford Motor Company

WILLIAM J. MCDONALD
Managing Partner
Wild Irishman Advisory, LLC

JORGE S. MESQUITA
Former Chief Executive Officer
BlueTriton Brands

BRAD D. SMITH
President
Marshall University

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, 2023

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. ☑

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). ☐

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, 2023 was $55,096,895,366 calculated using the average price on June 30, 2023 of $445.24 per share.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2024 was 120,653,315.

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 18, 2024. 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, 2023

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 committed to putting health first – for our teammates, our customers, and our company. Through our Humana insurance services, and our CenterWell health care services, we make it easier for the millions of people we serve to achieve their best health – delivering the care and service they need, when they need it. These efforts are leading to a better quality of life for people with Medicare, Medicaid, families, individuals, military service personnel, and communities at large.

As of December 31, 2023, we had approximately 17 million members in our medical benefit plans, as well as approximately 5 million members in our specialty products. During 2023, 84% of our total premiums and services revenue were derived from contracts with the federal government, including 14% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 851,300 members as of December 31, 2023.

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 2023 Form 10-K, contains both historical and forward-looking information. See Part I, Item 1A, "Risk Factors" of this Form 10-K for a description of a number of factors that may adversely affect our results or business.

Business Segments

During December 2022, we realigned our businesses into two distinct segments: Insurance and CenterWell. The Insurance segment includes the businesses that were previously included in the Retail and Group and Specialty segments, as well as the Pharmacy Benefit Manager, or PBM, business which was previously included in the Healthcare Services segment. The CenterWell segment (formerly Healthcare Services) represents our payor-agnostic healthcare services offerings, including pharmacy solutions, primary care, and home solutions. In addition to the

new segment classifications being utilized to assess performance and allocate resources, we believe this simpler structure will create greater collaboration across the Insurance and CenterWell businesses and will accelerate work that is underway to centralize and integrate operations within the organization. 2021 segment financial information was recast to conform to the 2022 presentation.

Our two reportable segments, Insurance and CenterWell, 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. These segment groupings are consistent with information used by our Chief Executive Officer, the Chief Operating Decision Maker, to assess performance and allocate resources. For additional information on our business segments and segment financial information, refer to Note 18 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

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, primary care, 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, or FFS, 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 Insurance Segment Products

The Insurance segment is comprised of products serving Medicare and state-based contract beneficiaries sold on a retail basis to individuals including medical and supplemental benefit plans. This segment also includes products consisting 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. In addition, our Insurance segment includes our military services business as well as the operations of our PBM business. These products are described in the discussion that follows.

The following table presents our premiums and services revenue for the Insurance segment by product for the year ended December 31, 2023:

	Insurance Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 78,837	74.9 %
Group Medicare Advantage	6,869	6.5 %
Medicare stand-alone PDP	2,189	2.1 %
Total Medicare	87,895	83.5 %
Commercial fully-insured	3,527	3.3 %
Specialty benefits	1,007	1.0 %
Medicare Supplement	735	0.7 %
State-based contracts and other	8,108	7.7 %
Total premiums revenue	101,272	96.2 %
Services:		
Commercial ASO	237	0.2 %
Military services and other	763	0.7 %
Services revenue	1,000	0.9 %
Total Insurance segment premiums and services revenue	$ 102,272	97.1 %

Medicare

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

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

Advantage plans to provide benefits at least comparable to those offered under Medicare FFS. Our Medicare Advantage, or MA, plans are discussed in the following sections. 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 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 account for certain demographic characteristics and health status of our enrolled members. 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, collected from providers, to calculate the health status-related risk-adjusted premium payment to MA plans, which CMS further adjusts for coding pattern differences between the health plans and the government fee-for-service (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 health status-adjusted 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. For additional information,

refer to Note 17 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" and Part I, Item 1A, "Risk Factors" of this Form 10-K.

At December 31, 2023, we provided health insurance coverage under CMS contracts to approximately 5,408,900 individual Medicare Advantage members, including approximately 851,300 members in Florida. These Florida contracts accounted for premiums revenue of approximately $14.9 billion, which represented approximately 19% of our individual Medicare Advantage premiums revenue, or 14% of our consolidated premiums and services revenue for the year ended December 31, 2023.

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 2024, and all of our product offerings filed with CMS for 2024 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 Walmart 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 audited Consolidated Financial Statements included in Item 8. – Financial Statements and Supplementary Data, titled “Receivables and Revenue Recognition.” 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 2024, and all of our product offerings filed with CMS for 2024 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 help pay the medical expenses that Medicare FFS does not cover, such as copayments, coinsurance and deductibles.

State-based 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, Illinois, Louisiana, Ohio, South Carolina and Wisconsin. We were awarded new Medicaid contracts in Oklahoma and Indiana, which we expect to become effective April 1, 2024 and July 1, 2024, respectively.

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.

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 implemented 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.

Group Commercial Coverage

In February 2023, we announced our planned exit from the Employer Group Commercial Medical Products business, which includes all fully insured, self-funded and Federal Employee Health Benefit medical plans, as well as associated wellness and rewards programs. No other Humana health plan offerings are materially affected. Following a strategic review, we determined the Employer Group Commercial Medical Products business was no longer positioned to sustainably meet the needs of commercial members over the long term or support our long-term strategic plans. The exit from this line of business will be phased over the 18 to 24 months following our February 2023 announcement.

We sell specialty and ancillary insurance benefits consisting of dental, vision, life and disability to employer groups. In addition, we sell dental and vision specialty insurance benefits to individuals.

For in-force group commercial medical customers and members, our commercial products 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.

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 active-duty and 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 6 million TRICARE beneficiaries. The T2017 East Region contract, which was originally set to expire on December 31, 2022, was subsequently extended by the DoD and is currently scheduled to expire on December 31, 2024, unless further extended.

In December 2022, we were awarded the next generation of TRICARE Managed Care Support Contracts, or T-5, for the updated TRICARE East Region by the Defense Health Agency of the DoD. The T-5 East Region contract comprises 24 states, and Washington D.C., and covers approximately 4.6 million beneficiaries. The transition period for the T-5 contract began in January 2024 and will overlap the final year of the T2017 contract. The length of the contract is one transition year followed by eight annual option periods, which, if all options are exercised, would result in a total contract length of nine years.

Our CenterWell Segment Products

The products offered by our CenterWell segment are key to our integrated care delivery model. This segment includes our pharmacy solutions, primary care, and home solutions operations. The CenterWell segment also includes our strategic partnerships with Welsh, Carson, Anderson & Stowe, or WCAS, to develop and operate senior-focused, payor-agnostic, primary care centers, as well as our minority ownership interest in hospice operations. 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. For information on our intersegment revenues, refer to Note 18 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

The following table presents our services revenue for the CenterWell segment by line of business for the year ended December 31, 2023:

	CenterWell Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenues:		
Home solutions	$ 1,589	n/a
Pharmacy solutions	10,451	n/a
Primary care	3,332	n/a
Total intersegment revenues	$ 15,372	n/a
External services revenue:		
Home solutions	$ 1,342	1.3 %
Pharmacy solutions	849	0.8 %
Primary care	842	0.8 %
Total external services revenue	$ 3,033	2.9 %

n/a – not applicable

Pharmacy Solutions

Our pharmacy solutions business includes the operations of CenterWell Pharmacy (our mail-order pharmacy business), CenterWell Specialty Pharmacy, and other retail pharmacies located within CenterWell Primary Care clinics for brand, generic, specialty drugs, over the counter medications and supplies, as well as hospice pharmacy drugs.

Primary Care

We operate full-service, value-based senior focused primary care centers in a number of states, including Georgia, Florida, Kansas, Louisiana, Missouri, Nevada, North Carolina, South Carolina, Texas, Arizona and Kentucky 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 Care Centers and CenterWell Senior Primary Care 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 296 primary care clinics and employs approximately 890 primary care providers. PCO serves approximately 294,200 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 Medicare FFS.

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 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. In May 2022, we established a second strategic partnership with WCAS to develop additional centers between 2023 and 2025. As of December 31, 2023, there were 108 primary care clinics operating under the partnership and we have capacity to open or acquire up to approximately 60 additional centers through the existing partnership agreements. For additional information, refer to Note 4 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

Home Solutions

CenterWell Home Health

We are actively involved in the care management of our customers with the greatest needs via in-home care. On August 17, 2021, we fully acquired Kindred at Home, or KAH, the nation's largest home health and hospice provider with locations in 40 states, providing extensive geographic coverage with approximately 65% overlap with our individual Medicare Advantage membership. Our home solutions geographic scale and clinical breadth provides the opportunity to offer care beyond our health plan members. We have fully-integrated the home health operations, now branded CenterWell Home Health, allowing us to accelerate clinical innovation and the development and roll out of 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.

Onehome

Onehome serves as the convener for the value-based model meeting the needs of health plans by serving their members through a full-risk model for integrated home-based services. Onehome manages a full range of post-acute patient needs, integrating and coordinating with physicians, hospitals and health plans for the provision of home health and infusion services as well as the distribution of durable medical equipment, or DME, at patients' homes. Onehome served 14% of our MA members with our value-based model as of December 31, 2023.

Hospice

Hospice care is an important offering in the full continuum of care we offer patients, and 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, on August 11, 2022, we completed the sale of a 60% interest in Gentiva (formerly Kindred) Hospice, to Clayton, Dubilier & Rice, or CD&R. Upon closing, Gentiva Hospice was restructured into a new stand-alone company. We continue to own a 35% minority ownership in Gentiva Hospice operations. For additional information on the sale of Gentiva Hospice, refer to Note 3 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

Insurance Medical Membership

The following table summarizes total insurance medical membership (in thousands) at December 31, 2023, by market and product:

	Insurance Medical Membership									
	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	851.3	9.1	131.9	17.5	656.6	73.8	24.5	—	1,764.7	10.50 %
Texas	446.0	4.6	202.7	29.2	—	49.8	29.9	—	762.2	4.50 %
Kentucky	138.1	74.2	169.2	10.0	160.3	51.1	51.0	—	653.9	3.90 %
Ohio	213.0	18.7	90.9	30.8	115.5	16.1	17.7	—	502.7	3.00 %
Georgia	348.9	3.1	81.2	9.7	—	33.9	56.9	—	533.7	3.20 %
North Carolina	251.2	175.3	96.0	5.7	—	—	—	—	528.2	3.10 %
Illinois	200.5	31.7	107.3	7.1	18.5	8.9	1.9	—	375.9	2.20 %
Tennessee	203.1	12.2	79.3	8.0	37.7	11.8	6.2	—	358.3	2.10 %
Louisiana	227.9	10.1	43.2	3.8	143.1	11.3	11.5	—	450.9	2.70 %
California	115.3	1.8	163.9	16.2	4.6	—	—	—	301.8	1.80 %
Missouri/Kansas	137.8	11.1	128.1	10.6	0.2	13.4	13.0	—	314.2	1.90 %
Michigan	154.8	31.7	75.0	4.7	—	0.4	1.7	—	268.3	1.60 %
Wisconsin	81.8	6.8	65.7	6.5	57.7	26.8	21.9	—	267.2	1.60 %
South Carolina	195.3	0.2	36.9	6.1	27.6	—	—	—	266.1	1.60 %
Indiana	150.9	11.4	65.9	12.4	—	8.5	7.4	—	256.5	1.50 %
Virginia	169.4	2.8	84.6	5.9	—	—	—	—	262.7	1.60 %
New York	144.6	12.1	67.2	7.3	1.0	—	—	—	232.2	1.40 %
Arizona	131.9	0.3	63.2	7.6	—	4.8	1.7	—	209.5	1.20 %
Pennsylvania	107.2	4.6	100.8	5.7	—	—	—	—	218.3	1.30 %
Mississippi	129.9	0.4	49.4	4.2	—	0.7	0.1	—	184.7	1.10 %
TRICARE	—	—	—	—	—	—	—	5,960.2	5,960.2	35.30 %
Others	1010.0	87.4	946.7	98.2	6.0	27.4	9.9	—	2,185.6	12.90 %
Totals	5,408.9	509.6	2,849.1	307.2	1,228.8	338.7	255.3	5,960.2	16,857.8	100.0 %

Provider Arrangements

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

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

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate 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 value-based arrangements represent a key element of our integrated care delivery model at the core of our strategy. Our health plan subsidiaries may enter into these value-based arrangements with third party providers or our owned provider subsidiaries.

At December 31, 2023, approximately 2,165,600 members, or 12.8% of our medical membership, were covered under shared risk value-based arrangements, which provide all member benefits, including 1,917,300 individual Medicare Advantage members, or 35.4% 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 289,000 HMO members, including 288,300 individual Medicare Advantage members, or 15.0% of the 1,917,300 individual Medicare Advantage members covered under value-based contracts at December 31, 2023, 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 $3.4 billion, or 3.9% of total benefits expense, for the year ended December 31, 2023. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Set, or HEDIS, which is used by employers, government purchasers

and the National Committee for Quality Assurance (NCQA) to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

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

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

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

NCQA reviews our compliance based on standards for quality improvement, population health management, credentialing, utilization management, network management, and member experience. We have achieved and maintained NCQA accreditation in many of our commercial, Medicare and Medicaid markets for HMO, POS, and PPO products, 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, wholesale distributors (general agencies) and direct mailings.

At December 31, 2023, we employed approximately 1,000 sales representatives, as well as approximately 2,500 telemarketing representatives who assisted in the marketing of Medicare products, including Medicare Advantage and PDP, and specialty products in our Insurance segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Walmart Inc., or Walmart, 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 Insurance segment, we market our specialty products to individuals through their employers or other groups, which typically offer employees or members a selection of specialty products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We use licensed independent brokers, independent agents, digital insurance agencies, and employees to sell our specialty 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 Part I, Item 1A, "Risk Factors" of this 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 Part I, Item 1A, "Risk Factors" of this 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 Intercompany Services

We provide centralized intercompany 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 services fee for reimbursement of certain centralized services provided to its subsidiaries to the extent that Humana Inc. is the service provider.

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, 2023, we had approximately 67,600 associates.

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 and a caring environment where our associates go above and beyond for our members, driving innovation, and offering fulfilling experiences that incentivizes them to stay with us over the long-term. We provide opportunities for our associates to add to their personal well-being experiences that go beyond health to enhance their individual need for purpose, belonging and security. On average, our associates spend 7 years at our Company, which is a testament to our commitment to their growth, well-being, and our culture, a culture that is further reinforced by our voluntary turnover rate, or VTR. We believe our VTR is an important indicator of workforce satisfaction as our associates continue to choose us over other opportunities. During 2023, our VTR was 13.4%, representing a decrease from 17% in 2022.

We regularly measure our success and seek opportunities to advance engagement through an Associate Experience Survey, or AES, and continuous listening campaigns. Continuous listening involves our proactive solicitation, analysis and response to associate feedback throughout the year by using pulse surveys. By regularly surveying samples of our workforce, we are able to continuously assess our effectiveness and act when needed, which in turn helps to strengthen our culture and support associate engagement. We aim to conduct a confidential, third-party administered AES on an annual basis and encourage all of our associates to participate. The AES is an in-depth survey covering eighteen dimensions that align to the Company's strategy and employee engagement. We aggregate survey results, provide them to our entire associate population and encourage leaders to use the information to create open, honest action plans with their teams to build upon our collective engagement.

Our culture is further strengthened by optimizing the well-being and effectiveness of our workforce. Through alternative work styles, such as home, hybrid home, office, hybrid office, and field, we help associates work more productively, communicate more easily and collaborate more freely. We encourage collaboration between leaders and their associates to identify and leverage the appropriate work style that both supports the achievement of business goals and personal work preferences. Alternate work styles enable associates to work from a job-appropriate location of their choice for all or some portion of their work schedule and to create a work schedule that better fits the diverse demands of today's work environment. When managed effectively, alternative work styles can enhance a company's employment brand, foster the development and effective delivery of innovative and diverse business solutions, right-size a company's energy-consumption footprint, and increase associate engagement and well-being.

Inclusion and Diversity

Our Office of Diversity, Equity & Inclusion, or DEI Office, efforts are led by our Chief Diversity, Equity & Inclusion Officer, who reports directly to the Chief Administrative Officer. The DEI Office connects to business groups across the enterprise to cultivate a diverse and inclusive culture that is representative of the communities we serve. By prioritizing DEI across our business, we enable associates to bring their whole selves to work, while also driving the innovation and insights needed to better serve our diverse members and communities. Together with key partners like our Chief Health Equity Officer, our Executive Diversity, Equity & Inclusion Council, or the Council, our Network Resource Groups, or NRGs, and Culture & Engagement professionals, we strive to expand our culture of inclusion to build deep relationships and create simple, personalized experiences for all of our stakeholders.

Our Council exists to help integrate inclusion, diversity, and equity into the fabric of the organization from the top down, connecting activities to a broader business-driven, results oriented strategy, and leverages leadership to advance DEI into the fabric of our culture. The Council reflects the diversity of our associates and communities we

serve. Chaired by our CEO, the Council sets its DEI objectives that complement our Talent and Diversity measure category and ensures transparency and accountability as they work towards them. We are committed to having diversity represented at all levels and have developed a pathway for diverse talent within our recruiting initiatives. 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.

Our inclusion and diversity objectives also aim to build an awareness of biases and beliefs, identify differences and similarities of our multi-generational workforce and enable associates to leverage differences to drive innovation and create value. We are committed to growing our associates' inclusion skills and diversity knowledge and provide a variety of associate training programs and workshop opportunities. It is also our fundamental belief that every person has the right to a safe workplace. This includes having freedom of gender identity and expression, which we have included within our non-discrimination and anti-harassment policies.

Our associates' vast experiences and perceptions, unique characteristics, backgrounds and beliefs, drive the groundbreaking, strategic thinking that gives our Company its competitive edge in a diverse marketplace. Our approach fosters innovative thinking and creativity, expands insights and generates better business outcomes.

Pay and Benefits Philosophy, Compensation and Financial Security

We believe all of our associates have the right to receive a competitive wage and we are committed to maintaining a pay and benefits philosophy that is market-based and recognizes an associate's contributions so that we can attract and retain an engaged, talented team. Further, we believe in fostering a fair and inclusive work environment, one where all associates receive equitable pay for their contributions. Each year, we conduct a comprehensive pay equity/gap analysis to identify and address potential pay disparities between associates performing similar work in similar capacities. Our pay and benefits structure is designed to motivate, incentivize 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, associate type and business, they generally include:

Financial	
• Competitive base pay, with additional incentive, supplemental, and/or recognition pay • 401(k) retirement savings plans with Company match program • Life insurance • Short - and long-term disability insurance	• Tuition assistance program • Paid internship • Charitable gift matching program • Comprehensive financial well-being programs and support, including and employer-sponsored personal emergency savings account with matching funds from the Company
Health	
• Medical, dental and vision benefits • Supplemental health benefits • Long-term care insurance • Whole-person well-being and rewards programs and platform • Incentives for engaging in well-being programs	• Health savings account (HSA) and flexible savings account (FSA) contributions • On-site health and fitness centers • On-site health screenings and vaccinations • Weekly paid well-being time • On-demand fitness classes, nutritional education through teaching kitchens, and digital coaching apps
Life	
• Paid time off, paid holidays, paid volunteer time off and jury duty pay • Adoption assistance • Paid parental leave program (6 weeks) • Paid caregiver time off program (2 weeks) • Nursing moms program with on-site lactation rooms	• Mental health support, including our robust Employee Assistance Program and Work-Life Services • Employee discount programs and services • Helping hands program • Transit services
Learning and Development	
• Diversity, equity, and inclusion training • Internal and external learning events	• Access to degree and certification programs with tuition assistance

Talent Development and Growth Opportunities

We champion the individual goals and development of our associates, and provide a number of programs and resources to support their efforts. The Humana Learning Center gives our associates the opportunity 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. We also utilize development programs to enhance talent within our business segments 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 18, 2024 appearing under the caption "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, 2024, their positions, and the date first elected as an executive officer**:**

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	61	Chief Executive Officer, Director	12/11	(1)
Vishal Agrawal, M.D.	49	Chief Strategy and Corporate Development Officer	12/18	(2)
Samir M. Deshpande	59	Chief Information Officer	07/17	(3)
Susan M. Diamond	50	Chief Financial Officer	07/19	(4)
John-Paul W. Felter	40	Senior Vice President, Chief Accounting Officer and Controller	08/22	(5)
William K. Fleming, PharmD	56	Chief Corporate Affairs Officer	03/17	(6)
Timothy S. Huval	57	Chief Administrative Officer	12/12	(7)
James. A. Rechtin	53	President and Chief Operating Officer	01/24	(8)
George Renaudin II	55	President, Medicare & Medicaid	02/23	(9)
Sanjay K. Shetty, M.D.	50	President, CenterWell	04/23	(10)
Joseph C. Ventura	47	Chief Legal Officer	02/19	(11)

(1) Mr. Broussard currently serves as Director 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) 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.

(4) 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.

(5) Mr. Felter currently serves as Senior Vice President, Chief Accounting Officer and Controller, having been elected to this position in August 2022. Before joining the Company, Mr. Felter served as Senior Director - Investment Finance for OneAmerica Financial Partners, Inc. in 2022. Prior to OneAmerica, Mr. Felter spent nearly 11 years in multiple roles of increasing responsibility at Ernst & Young LLP where he oversaw large audit engagements for public and private entities with a concentration in the health insurance sector.

(6) Dr. Fleming currently serves as Chief Corporate Affairs Officer, having been elected to this position in April 2023, from his prior role as Segment President, Pharmacy Solutions and Chief Corporate Affairs Officer. Prior to that, Dr. Fleming held positions of Segment President, Clinical and Pharmacy Solutions, Segment President, Healthcare Services, and 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) Mr. Rechtin currently serves as President and Chief Operating Officer, having been elected to this position in January 2024. Prior to joining the Company, Mr. Rechtin served as President and CEO at Envision Healthcare, having held that position from 2020 to 2023. Previously, Mr. Rechtin was President of OptumCare in 2019 after serving in multiple senior-level roles at Davita Medical Group from 2014 to 2019.

(9) Mr. Renaudin currently services as President, Medicare & Medicaid, having been elected to this position in February 2023. Mr. Renaudin joined the Company in April 2004 and since then has held various leadership roles of increasing responsibility, most recently holding the position of President, Medicare.

(10) Dr. Shetty currently serves as President, CenterWell, having been elected to this position in April 2023. Prior to joining the Company, Dr. Shetty spent nearly 13 years at Steward Health Care System in multiple senior-level roles, including President of Steward North America, President, Steward South Region and Executive Vice President, President, Steward Medical Group and Executive Vice President, Steward Health Care System, Executive Vice President for Corporate and Business Development, and President, Steward Health Care Network.

(11) Mr. Ventura currently serves as Chief Legal Officer. He joined the Company in January 2009 and since then has held various positions of increasing responsibility in the Company's Law Department, including most recently, Senior Vice President, Associate General Counsel & Corporate Secretary from July 2017 until February 2019.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. Pursuant to our previously announced leadership succession plan, we expect that Mr. Broussard will step down as Chief Executive Officer in the latter half of 2024 and that Mr. Rechtin will become President and Chief Executive Officer at that time. 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 rebates received from manufacturers and wholesalers;
- pharmacy volume rebates received from drug manufacturers, which in Medicare Part D are fully reported to CMS and factored into member premium pricing and CMS reimbursement to the plan;
- catastrophes, including acts of terrorism, public health emergencies, epidemics or pandemics (such as 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, inflation, 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. 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 and regulatory 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 services 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, which are of particular importance given the concentration of our revenues in these products, our state-based contracts strategy, the growth of our CenterWell businesses, and our integrated care delivery model, our business may be materially adversely affected. 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, our strategy with respect to state-based contracts, including those covering members dually eligible for the Medicare and Medicaid programs, the growth of our pharmacy,

primary care, and home solutions businesses, and the successful implementation of our integrated care delivery model.

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. The misappropriation of our proprietary information 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 systems against cybersecurity attacks, contain such attacks when they occur, 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 with which we do business. We have been, and will likely continue to be, regular targets of attempted cybersecurity attacks and other security threats and may be, and have been, subject to breaches of our information technology systems, including breaches of the information technology systems of third-party service providers. 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, 2023, 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, or that such an attack will not be material to our business, in the future. A cybersecurity attack may penetrate our layered security controls and lead to the misappropriation of or compromise of sensitive personal information or proprietary or confidential information, create system disruptions, cause shutdowns, or deploy viruses, ransomware, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our information technology systems, or the security of third-party service providers, could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential information or intellectual property, operational or business delays resulting from the disruption of our IT systems, extortion attempts, 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, can 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, or against our health plans 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; 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 audited 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 services, and Medicaid programs. These programs accounted for approximately 91% of our total premiums and services revenue for the year ended December 31, 2023. These programs involve various risks, as described further below.

- At December 31, 2023, under our contracts with CMS we provided health insurance coverage to approximately 851,300 individual Medicare Advantage members in Florida. These contracts accounted for approximately 14% of our total premiums and services revenue for the year ended December 31, 2023. 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 changes to the Part D prescription drug benefit design (such as the changes to plan sponsor liability across the different Part D coverage phases that will apply beginning in plan year 2025) or 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.
- Our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2023, primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract comprises 32 states and covers approximately 6.0 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract, which was originally set to expire on December 31, 2022, was subsequently extended by the United States Department of Defense, or DoD, and is currently scheduled to expire on December 31, 2024 unless further extended. In December 2022, we were awarded the next generation of TRICARE Managed Care Support Contracts, or T-5, for the updated TRICARE East Region by the DoD. The T-5 East Region contract comprises 24 states and Washington, D.C., and covers approximately 4.6 million beneficiaries. The transition period for the T-5 contract began in January 2024 and will overlap the final year of the T2017 contract. The T-5 East Region contract includes certain provisions pursuant to which we have guaranteed certain discounts to expected costs over the life of the contract. The loss of the T2017 or T-5 East Region contracts, should either occur, or our failure to deliver

on the contractually agreed discounts, may have a material adverse effect on our results of operations, financial position, and cash flows.

- 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 account for certain demographic characteristics and health status of our enrolled members. 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, collected from providers, to calculate the health status-related risk-adjusted premium payment to MA plans, which CMS further adjusts for coding pattern differences between the health plans and the government fee-for-service (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 health status-adjusted 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.

  CMS and the Office of the Inspector General of Health and Human Services, or HHS-OIG, perform audits of various companies' risk adjustment diagnosis data submissions. 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 that influence the calculation of health status-related premium payments to MA plans.

  In 2012, CMS released an MA contract-level RADV methodology that would extrapolate the results of each CMS RADV audit sample to the audited MA contract's entire health status-related risk adjusted premium amount for the year under audit. In doing so, CMS recognized "that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model (FFS claims)." To correct for this difference, CMS stated that it would apply a "Fee-for-Service Adjuster (FFS Adjuster)" as "an offset to the preliminary recovery amount." This adjuster would be "calculated by CMS based on a RADV-like review of records submitted to support FFS claims data." CMS stated that this methodology would apply to audits beginning with PY 2011. Humana relied on CMS's 2012 guidance in submitting MA bids to CMS. Humana also launched a "Self-Audits" program in 2013 that applied CMS's 2012 RADV audit methodology and included an estimated FFS Adjuster. Humana completed Self-Audits for PYs 2011-2016 and reported results to CMS.

  In October 2018, however, CMS issued a proposed rule announcing possible changes to the RADV audit methodology, including elimination of the FFS Adjuster. CMS proposed applying its revised methodology, including extrapolated recoveries without application of a FFS Adjuster, to RADV audits dating back to PY 2011. On January 30, 2023, CMS published a final rule related to the RADV audit methodology (Final RADV Rule). The Final RADV Rule confirmed CMS's decision to eliminate the FFS Adjuster. The Final RADV Rule states CMS's intention to extrapolate results from CMS and HHS-OIG RADV audits beginning with PY 2018, rather than PY 2011 as proposed. However, CMS's Final RADV Rule does not adopt a specific sampling, extrapolation or audit methodology. CMS instead stated its general plan to rely on "any statistically valid method . . . that is determined to be well-suited to a particular audit."

We believe that the Final RADV Rule fails to address adequately the statutory requirement of actuarial equivalence and violates the Administrative Procedure Act ("APA"). CMS failed to meet its legal obligations in the federal rulemaking process to give a reasoned justification for the rule or provide a meaningful opportunity for public comment. They also chose to apply the rule retroactively rather than prospectively, as required by law. Humana's actuarially certified bids through PY 2023 preserved Humana's position that CMS should apply an FFS Adjuster in any RADV audit that CMS intends to extrapolate. We expect CMS to apply the Final RADV Rule, including the first application of extrapolated audit results to determine audit settlements without a FFS Adjuster, to CMS and HHS-OIG RADV audits conducted for PY 2018 and subsequent years. The Final RADV Rule, including the lack of a FFS Adjuster, 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.

On September 1, 2023, Humana Inc. and Humana Benefit Plan of Texas, Inc. filed suit against the United States Department of Health and Human Services, and Xavier Becerra in his official capacity as Secretary, in the United States District Court, Northern District of Texas, Fort Worth Division seeking a determination that the Final RADV Rule violates the APA and should be set aside. We remain committed to working alongside CMS to promote the integrity of the MA program as well as affordability and cost certainty for our members. It is critical that MA plans are paid accurately and that payment model principles, including the application of a FFS Adjuster, 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 until CMS completes the applicable final payment year reconciliation, including member eligibility differences with CMS incurred allowable drug costs after rebates and other discounts, and low-income subsidy amounts.

  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 or other changes to the Part D prescription drug benefit design 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.

- Our primary care and home health businesses derive a substantial portion of their revenues from third-party payors and directly from the federal and state governments through participation in fee-for-service Medicare. This concentration of revenues subjects these businesses to reductions in Medicare reimbursement rates or changes in the rules governing the Medicare program, including changes to CMS's risk adjustment model that may apply to our primary care business through its contracts with third-party payors. It is reasonably possible that such changes in reimbursement rates or changes to the Medicare programs in which our primary care and home health business participate may have a material adverse effect on our results of operations, financial position, or cash flows.

- We are 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 temporary or permanent exclusion from participating in various government health care programs (such as Medicare and Medicaid), 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.

New Laws or Regulations, or Future Legislative, Judicial or Regulatory Changes

We are and will continue to be regularly subject to new laws and regulations, changes to existing laws and regulations, and judicial determinations that impact the interpretation and applicability of those laws and regulations. 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), the Families First Coronavirus Response Act (the

"Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), and the Inflation Reduction Act of 2022 (the "Inflation Reduction Act"), and related regulations, are examples of laws which have enacted significant reforms to various aspects of the U.S. health insurance industry, including 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, the introduction of plan designs based on set actuarial values, and changes to the Part D prescription drug benefit design.

It is reasonably possible that these laws and regulations, as well as other current or future legislative, judicial or regulatory changes, including restrictions on our ability to manage our provider network, market and sell our products, 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 (and uncertainty arising from the implementation of these changes) 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 these laws and regulations, including the Health Care Reform Law or declare all or certain portions of these laws and regulations unconstitutional or contrary to law, 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 be materially impacted if they are unable to maintain relationships with these companies, or fail to adequately negotiate the terms of their contracts with these third-party payers, including the price and other terms of fixed fee (or capitated) agreements under which our primary care business assumes the risk that the actual cost of a basket of services provided to a patient exceeds the reimbursement provided by the health plan 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 subjects 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 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 CenterWell 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.

Volatility or disruption in the securities and credit markets, including changes in interest rates, may significantly and adversely affect the value of our investment portfolio and the investment income that we derive from this portfolio.

Ongoing volatility or disruption in the securities and credit markets, including changes in interest rates, may significantly and adversely affect the value of our significant investment portfolio and the investment income that we derive from this 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, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

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

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 1C. CYBERSECURITY

Risk Management and Strategy

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. The protection of information and business processes is an integrated component in our overall risk management program, and reflected in our Code of Ethics, security standards, and privacy policies. We employ processes to safeguard information and protect our members' data, including by deploying both proactive and defensive practices against the evolving cyber threat landscape. Examples of these processes include:

a. Employing a qualified Chief Information Security Officer.
b. Maintaining tools to identify malicious cyber activity.
c. Monitoring risks posed by threat actors, including through partnerships with industry groups and government agencies.
d. Providing annual cybersecurity training to our associates.
e. Testing our associates' knowledge through internal phishing simulations.
f. Engaging an independent third-party audit firm to perform an Annual Service Organizational Controls (SOC) 2 audit of enterprise claims platforms.
g. Reporting data breaches, as required by law, to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), and various state agencies; our reports are publicly available, free of charge, and can be obtained through the OCR Portal at https://ocrportal.hhs.gov/ocr/breach.
h. Maintaining a program to identify cybersecurity risks associated with certain third party vendors, which is one component of an overall vendor risk management program.

We also enhance our information technology infrastructure and security protocols to assess, identify, protect against, and manage material risks from cybersecurity threats following a risk-based approach. In addition, we conduct cybersecurity risk assessments at least annually, and periodically engage an independent auditor or other external assessors to aid in pro-active risk identification, prevention, detection, mitigation, and remediation. Our efforts to manage against cybersecurity threats are further guided by Federal and state laws, as well as contractual

commitments with third parties, which regulate our collection, use and disclosure of confidential information such as protected health information and personally identifiable information.

Although we have been subject to breaches of our information technology systems, including breaches of the information technology systems of third-party service providers, the impact of such attacks has not been material to our business strategy, operations or results of operations, financial position, or cash flows through December 31, 2023. We do not believe that cybersecurity threats resulting from any previous cybersecurity incidents of which we are aware are reasonably likely to materially affect the Company. For additional information on the risks we face from cybersecurity threats, please refer to Part I, Item 1A, "Risk Factors" of this Form 10-K.

Governance

As part of its overall responsibility for oversight of our enterprise risk management, our Board of Directors reviews material risks to our Company, including risks from cybersecurity threats. The Board has designated our Audit Committee and Technology Committee with joint oversight over our information technology internal controls, cybersecurity, business continuity and disaster recovery programs.

Management is responsible for designing and implementing our governance framework and controls for managing our material risks from cybersecurity threats, under the oversight of our Board of Directors. Our Chief Information Security Officer is responsible for assessing and managing identified cybersecurity risks, and evaluating and remediating cybersecurity incidents, and sharing information directly with the Audit Committee and Technology Committee, or full Board of Directors, when appropriate. Our Chief Information Security Officer reports to our Chief Information Officer, who is in turn responsible for the management of Humana's data and information technology risks more generally. Our Chief Information Officer is a senior executive and industry leader in risk management practices in highly regulated fields. Our Chief Information Security Officer is an experienced cybersecurity executive and leader in the field, with many years of relevant experience working in highly regulated industries.

Among our cybersecurity and risk teams, we utilize established governance mechanisms to enable a transparent and holistic approach to cybersecurity risk management, and the evaluation and remediation of cybersecurity incidents. These processes enable cross-functional engagement from our enterprise information protection, enterprise risk management, enterprise compliance, information technology, legal, privacy, and data governance teams.

As a key component of this governance framework, the Audit Committee and Technology Committee also receive regular updates regarding our cybersecurity program and cybersecurity incidents from our Chief Information Security Officer.

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; and Austin, Texas.

We owned or leased numerous medical centers and administrative offices at December 31, 2023. 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 324 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 audited 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, 2024, there were 1,602 holders of record of our common stock and 637,767 beneficial holders of our common stock.

Dividends

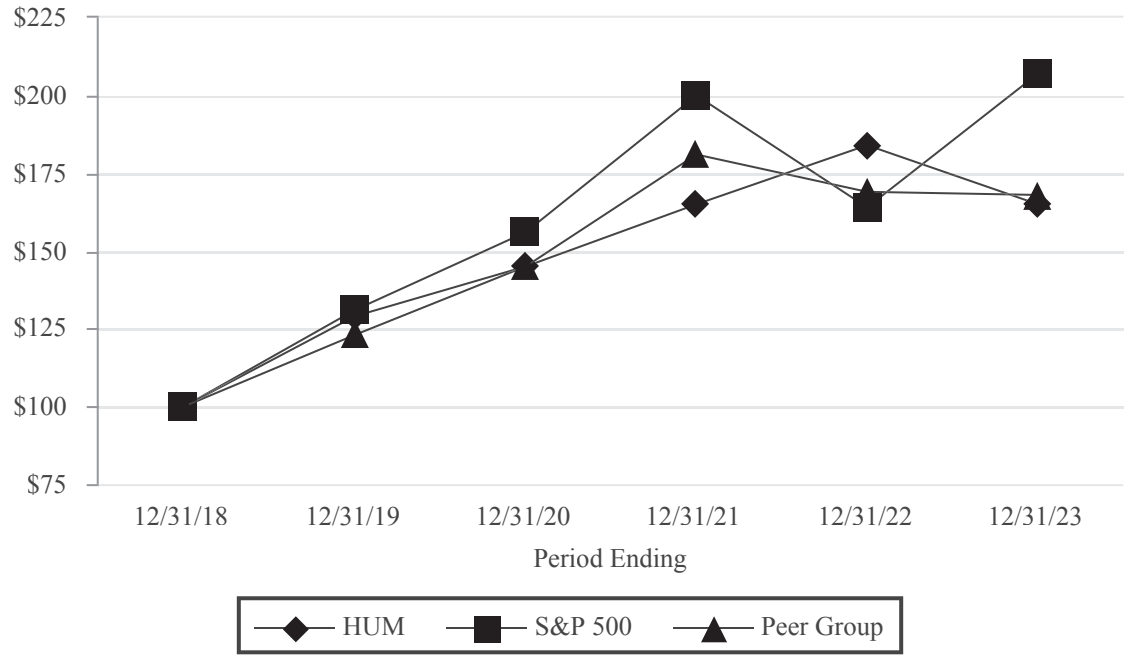
The following table provides details of dividend payments, excluding dividend equivalent rights, in 2022 and 2023, under our Board approved quarterly cash dividend policy:

Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2022 payments			
12/31/2021	1/28/2022	$0.7000	$90
3/31/2022	4/29/2022	$0.7875	$100
6/30/2022	7/29/2022	$0.7875	$100
9/30/2022	10/28/2022	$0.7875	$100
2023 payments			
12/30/2022	1/27/2023	$0.7875	$98
3/31/2023	4/28/2023	$0.8850	$111
6/30/2023	7/28/2023	$0.8850	$110
9/29/2023	10/27/2023	$0.8850	$109

In October 2023, the Board declared a cash dividend of $0.8850 per share payable on January 26, 2024 to stockholders of record on December 29, 2023 for an aggregate amount of $108 million. In February 2024, the Board declared a cash dividend of $0.885 per share payable on April 26, 2024 to stockholders of record on March 29, 2024. 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, 2023. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2018, and that dividends were reinvested when paid.



	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023
HUM	$ 100	$ 129	$ 145	$ 165	$ 184	$ 165
S&P 500	$ 100	$ 131	$ 156	$ 200	$ 164	$ 207
Peer Group	$ 100	$ 123	$ 145	$ 181	$ 169	$ 168

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, 2023 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 2023	220,245	$ 507.67	220,245	$ 1,917,683,190
November 2023	860,260	485.36	860,260	1,500,150,885
December 2023	—	—	—	1,500,150,885
Total	1,080,505		1,080,505	

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

(2) On February 15, 2023, the Board of Directors replaced the previous share repurchase authorization of up to $3 billion (of which approximately $1 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 as of February 15, 2026, which we refer to as the February 2023 repurchase authorization. Our remaining repurchase authorization under the February 2023 repurchase authorization was $824 million as of February 15, 2024.

ITEM 6. [Reserved]

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

For discussion of 2021 items and year-over-year comparisons between 2022 and 2021 that are not included in this 2023 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, 2022, that was filed with the Securities and Exchange Commission on February 16, 2023.

Executive Overview

General

Humana Inc., headquartered in Louisville, Kentucky, is committed to putting health first – for our teammates, our customers, and our company. Through our Humana insurance services, and our CenterWell health care services, we make it easier for the millions of people we serve to achieve their best health – delivering the care and service they need, when they need it. These efforts are leading to a better quality of life for people with Medicare, Medicaid, families, individuals, military service personnel, and communities at large.

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

Employer Group Commercial Medical Products Business Exit

In February 2023, we announced our planned exit from the Employer Group Commercial Medical Products business, which includes all fully insured, self-funded and Federal Employee Health Benefit medical plans, as well as associated wellness and rewards programs. No other Humana health plan offerings are materially affected. Following a strategic review, we determined the Employer Group Commercial Medical Products business was no longer positioned to sustainably meet the needs of commercial members over the long term or support our long-term strategic plans. The exit from this line of business will be phased over the 18 to 24 months following our February 2023 announcement.

Sale of Hospice and Personal Care Divisions

On August 11, 2022, we completed the sale of a 60% interest in Gentiva (formerly Kindred) Hospice to Clayton, Dubilier & Rice, or CD&R, for cash proceeds of approximately $2.7 billion, net of cash disposed, including debt repayments from Gentiva Hospice to Humana of $1.9 billion. In connection with the sale we recognized a pre-tax gain, net of transaction costs, of $237 million, which was reported as a gain on sale of Gentiva Hospice in the accompanying consolidated statements of income for the year ended December 31, 2022.

COVID-19

The emergence and spread of the novel coronavirus, or COVID-19, beginning in the first quarter of 2020 has impacted our business. Initially during periods of increased incidences of COVID-19, a reduction in non-COVID-19 hospital admissions for non-emergent and elective medical care resulted in lower overall healthcare system utilization. At the same time, COVID-19 treatment and testing costs increased utilization. During 2022, we experienced lower overall utilization of the healthcare system than anticipated, as the reduction in COVID-19 utilization following the increased incidence associated with the Omicron variant outpaced the increase in non-COVID-19 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 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 2021.

The COVID-19 National Emergency declared in 2020 was terminated on April 10, 2023 and the Public Health Emergency expired on May 11, 2023.

Value Creation Initiatives and Impairment Charges

In order to create capacity to fund growth and investment in our Medicare Advantage business and further expansion of our healthcare services capabilities beginning in 2022, we committed to drive additional value for the enterprise through cost saving, productivity initiatives, and value acceleration from previous investments. As a result of these initiatives, we recorded charges of $436 million and $473 million in 2023 and 2022, respectively, within operating costs in the consolidated statements of income. These charges were recorded at the corporate level and not allocated to the segments. We expect to incur additional charges through the end of 2024.

The value creation initiative charges primarily relate to $237 million and $248 million in asset impairments in 2023 and 2022, respectively, as well as $199 million and $116 million in severance charges in connection with workforce optimization in 2023 and 2022, respectively. The remainder of the 2022 charges primarily relate to external consulting fees.

During 2023, we also recorded severance charges of $70 million within operating costs in our consolidated statement of income as a result of our exit from the Employer Group Commercial Medical Products business and impairment charges of $91 million, including $55 million relating to indefinite-lived intangibles. The indefinite-lived intangibles impairment charges were included within operating costs in our consolidated statement of income with the remaining impairment charges included within investment income.

Business Segments

During December 2022, we realigned our businesses into two distinct segments: Insurance and CenterWell. The Insurance segment includes the businesses that were previously included in the Retail and Group and Specialty segments, as well as the Pharmacy Benefit Manager, or PBM, business which was previously included in the Healthcare Services segment. The CenterWell segment (formerly Healthcare Services) represents our payor-agnostic healthcare services offerings, including pharmacy solutions, primary care, and home solutions. In addition to the new segment classifications being utilized to assess performance and allocate resources, we believe this simpler structure will create greater collaboration across the Insurance and CenterWell businesses and will accelerate work that is underway to centralize and integrate operations within the organization. 2021 segment financial information was recast to conform to the 2022 presentation.

Our two reportable segments, Insurance and CenterWell, 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. For segment financial information, refer to Note 18 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

The Insurance segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts, as well as 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. This segment also includes products consisting 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. In addition, our Insurance segment includes our military services business, primarily our T-2017 East Region contract, as well as the operations of our PBM business.

The CenterWell segment includes our pharmacy solutions, primary care, and home solutions operations. The segment also includes our strategic partnerships with WCAS to develop and operate senior-focused, payor-agnostic, primary care centers, as well as our minority ownership interest in Gentiva Hospice operations. 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.

The results of each segment are measured by income (loss) from operations. Transactions between reportable segments primarily consist of sales of services rendered by our CenterWell segment, primarily pharmacy solutions, primary care, and home solutions, to our Insurance 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.

One of the product offerings of our Insurance segment is Medicare stand-alone prescription drug plans, or PDP, under the Medicare Part D program. Our quarterly Insurance 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.

The Insurance segment also experiences seasonality in the commercial fully-insured product offering. The effect on the Insurance segment benefit ratio is opposite of the Medicare stand-alone PDP impact, with the benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses. The Employer Group Commercial Fully-Insured business did not impact the Insurance segment benefit ratio for the year ended December 31, 2023 and increased the Insurance segment benefit ratio by 10 basis points for the year ended December 31, 2022.

The Insurance 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. The Insurance segment may experience adverse impacts in the operating cost ratio as a result of our Employer Group Commercial Medical Products exit phased over the 18 to 24 months following our February 2023 announcement. The Employer Group Commercial Fully-Insured business increased the Insurance segment operating cost ratio by 30 basis points and increased the Insurance segment operating cost ratio by 40 basis points for the years ended December 31, 2023 and 2022, respectively.

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, 2023, approximately 3,764,300 members, or 70%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 3,175,500 members, or 70%, at December 31, 2022.

- On January 31, 2024, Centers for Medicare & Medicaid Services, or CMS, issued its preliminary 2025 Medicare Advantage and Part D payment rates and proposed policy changes, collectively, the Advance Notice. CMS has invited public comment on the Advance Notice before publishing final rates on or before April 1, 2024, or the Final Notice. In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 0.16% decrease in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee-for-service county rebasing/re-pricing since the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. Based on our preliminary analysis using the same factors included in CMS' estimate, the components of which are detailed on CMS' website, we anticipate the proposals in the Advance Notice would result in a change to our benchmark funding that is approximately 160 basis points worse than our expectation of a flat rate environment. This difference is primarily due to the proposed effective growth rate restatements, which we did not anticipate in light of the higher medical cost trends experienced across the industry, as well as the negative impact of CMS' proposed normalization factors. As part of our typical engagement with the agency, we will provide actuarial data with respect to our concerns regarding these items. We will continue to analyze the Advance Notice and will draw upon our program expertise to provide CMS formal commentary on the impact of the Advance Notice and the related impact upon Medicare beneficiaries' quality of care, affordability, and service to its members through the Medicare Advantage program.

- Net income attributable to Humana was $2.5 billion, or $20.00 per diluted common share, and $2.8 billion, or $22.08 per diluted common share, in 2023 and 2022, respectively. This comparison was significantly impacted by the gain on sale of Gentiva Hospice, put/call valuation adjustments associated with non-consolidating minority interest investments, transaction and integration costs, the change in the fair market value of publicly-traded equity securities, an accrued charge related to certain litigation expenses, charges associated with value creation initiatives, and impairment charges. 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 the 2023 and 2022 periods:

	2023	2022
	(in millions)	
Consolidated income before income taxes and equity in net (losses) earnings:		
Gain on sale of Gentiva Hospice	$ —	$ (237)
Put/call valuation adjustments associated with our non-consolidating minority interest investments	320	68
Transaction and integration costs	(48)	105
Change in fair market value of publicly-traded equity securities	(1)	123
Accrued charge related to certain anticipated litigation expenses	105	—
Value creation initiatives	436	473
Impairment charges	91	—
Total	$ 903	$ 532

	2023	2022
Diluted earnings per common share:		
Gain on sale of Gentiva Hospice	$ —	$ (1.86)
Put/call valuation adjustments associated with our non-consolidating minority interest investments	2.57	0.53
Transaction and integration costs	(0.38)	0.83
Change in fair market value of publicly-traded equity securities	(0.01)	0.97
Accrual charge related to certain anticipated litigation expenses	0.84	—
Value creation initiatives	3.50	3.72
Impairment charges	0.73	—
Net tax impact of transactions	(1.67)	(1.52)
Total	$ 5.58	$ 2.67

Regulatory Environment

We are and will continue to be regularly subject to new laws and regulations, changes to existing laws and regulations, and judicial determinations that impact the interpretation and applicability of those laws and regulations. The Health Care Reform Law, the Families First Act, the CARES Act, and the Inflation Reduction Act, and related regulations, are examples of laws which have enacted significant reforms to various aspects of the U.S. health insurance industry, including, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with insurance products, 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, and changes to the Part D prescription drug benefit design.

It is reasonably possible that these laws and regulations, as well as other current or future legislative, judicial or regulatory changes including restrictions on our ability to manage our provider network, manage and sell our products, 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, increases in regulation of our prescription drug benefit businesses, or changes to the Part D prescription drug benefit design (and uncertainty arising from the implementation of these changes) 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 CenterWell segment, primarily pharmacy solutions, primary care, and home solutions, to our Insurance segment customers and are described in Note 18 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

Comparison of Results of Operations for 2023 and 2022

The following discussion primarily details our results of operations for the year ended December 31, 2023, or the 2023 period, and the year ended December 31, 2022, or the 2022 period.

Consolidated

			Change	
	2023	2022	Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Insurance premiums	$ 101,272	$ 87,712	$ 13,560	15.5 %
Services:				
Insurance	1,000	850	150	17.6 %
CenterWell	3,033	3,926	(893)	(22.7)%
Total services revenue	4,033	4,776	(743)	(15.6)%
Investment income	1,069	382	687	179.8 %
Total revenues	106,374	92,870	13,504	14.5 %
Operating expenses:				
Benefits	88,394	75,690	12,704	16.8 %
Operating costs	13,188	12,671	517	4.1 %
Depreciation and amortization	779	709	70	9.9 %
Total operating expenses	102,361	89,070	13,291	14.9 %
Income from operations	4,013	3,800	213	5.6 %
Gain on sale of Gentiva Hospice	—	(237)	(237)	(100.0)%
Interest expense	493	401	92	22.9 %
Other expense, net	137	68	69	101.5 %
Income before income taxes and equity in net losses	3,383	3,568	(185)	(5.2)%
Provision for income taxes	836	762	74	9.7 %
Equity in net losses	(63)	(4)	59	1475.0 %
Net income	$ 2,484	$ 2,802	$ (318)	(11.3)%
Diluted earnings per common share	$ 20.00	$ 22.08	$ (2.08)	(9.4)%
Benefit ratio (a)	87.3 %	86.3 %		1.0 %
Operating cost ratio (b)	12.5 %	13.7 %		(1.2)%
Effective tax rate	25.2 %	21.4 %		3.8 %

(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 revenue increased $13.6 billion, or 15.5%, from $87.7 billion in the 2022 period to $101.3 billion in the 2023 period primarily due to individual Medicare Advantage and state-based contracts membership growth and higher per member individual Medicare Advantage premiums. These factors were partially offset by the year-over-year decline in membership associated with group commercial medical, group Medicare Advantage and stand-alone PDP products, as well as the phase-out of COVID-19 sequestration relief in 2022.

Services Revenue

Consolidated services revenue decreased $0.7 billion, or 15.6%, from $4.8 billion in the 2022 period to $4.0 billion in the 2023 period primarily due to the divestiture of the 60% ownership of Gentiva Hospice in August 2022.

Investment Income

Investment income increased $0.7 billion, or 179.8%, from $0.4 billion in the 2022 period to $1.1 billion in the 2023 period primarily due to increase in interest income on our debt securities as well as the net unfavorable mark to market impact of our publicly-traded equity securities during the 2022 period.

Benefits Expense

Consolidated benefits expense increased $12.7 billion, or 16.8%, from $75.7 billion in the 2022 period to $88.4 billion in the 2023 period. The consolidated benefit ratio increased 100 basis points from 86.3% in the 2022 period to 87.3% in the 2023 period primarily due to investments in the benefit design of our Medicare Advantage products for 2023, higher than anticipated Medicare Advantage utilization trends, which further increased in the fourth quarter of 2023, driven by inpatient utilization, primarily for the months of November and December, and non-inpatient trends, predominately in the categories of physician, outpatient surgeries and supplemental benefits, as well as the impact of continued individual Medicare Advantage growth following the 2023 Annual Election Period, or AEP, including a high proportion of age-ins, which typically have a higher benefits expense ratio initially than the average new member. These increases were partially offset by increased individual Medicare Advantage premiums, decreased average unit costs given the additional 20% payment on COVID-19 admissions during the Public Health Emergency, which expired on May 11, 2023, as well as higher favorable prior-period development in 2023. Further, the 2023 ratio continues to reflect a shift in line of business mix, with growth in individual Medicare Advantage and state-based contracts and other membership, which can carry a higher benefits expense ratio.

Consolidated benefits expense included $872 million of favorable prior-period medical claims reserve development in the 2023 period and $415 million of favorable prior-period medical claims reserve development in the 2022 period. Prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 90 basis points in the 2023 period and decreased the consolidated benefit ratio by approximately 50 basis points in the 2022 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 $0.5 billion, or 4.1%, from $12.7 billion in the 2022 period to $13.2 billion in the 2023 period. The consolidated operating cost ratio decreased 120 basis points from 13.7% in the 2022 period to 12.5% in the 2023 period. The ratio decrease was primarily due to the divestiture of the 60% ownership of Gentiva Hospice in August 2022, which carried a significantly higher operating cost ratio compared to the historical consolidated operating cost ratio, scale efficiencies associated with growth in individual Medicare Advantage membership, administrative cost efficiencies as a result of our value creation initiatives, as well as the impact of significantly reduced compensation accruals in 2023 for the annual incentive plan offered to employees across all levels of the company, in accordance with plan requirements, as our 2023 performance was negatively impacted by the previously-discussed higher Medicare Advantage utilization trends. These factors were partially offset by an

increase in commissions for brokers related to the individual Medicare Advantage membership growth in 2023, the impact of accelerated charges related to value creation initiatives in 2023 compared to 2022, impairment charges expensed in 2023, the phase-out of COVID-19 sequestration relief in 2022, and an accrual recorded in 2023 related to certain anticipated litigation expenses.

Depreciation and Amortization

Depreciation and amortization increased $70 million, or 9.9%, from $709 million in the 2022 period to $779 million in the 2023 period primarily due to capital expenditures.

Interest Expense

Interest expense increased $92 million, or 22.9%, from $401 million in the 2022 period to $493 million in the 2023 period primarily due to higher average interest cost on outstanding borrowings.

Income Taxes

Our effective tax rate during 2023 was 25.2% compared to the effective tax rate of 21.4% in 2022. The year-over-year increase in the effective income tax rates is primarily due to the favorable adjustment in relation to tax basis over book basis for the sale of Gentiva Hospice recognized in 2022, which resulted in book income in excess of taxable gain, an increase in our federal and state audit reserves for 2023, as well as a reduction in the recognized value of certain net operating losses. For a complete reconciliation of the federal statutory rate to the effective tax rate, refer to Note 12 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

Insurance Segment

	2023	2022	Change Members	Change %
Membership:				
Individual Medicare Advantage	5,408,900	4,565,600	843,300	18.5 %
Group Medicare Advantage	509,600	565,100	(55,500)	(9.8)%
Medicare stand-alone PDP	2,849,100	3,551,300	(702,200)	(19.8)%
Total Medicare	8,767,600	8,682,000	85,600	1.0 %
Medicare Supplement	307,200	313,600	(6,400)	(2.0)%
Commercial fully-insured	338,700	556,300	(217,600)	(39.1)%
State-based contracts and other	1,228,800	1,137,300	91,500	8.0 %
Military services	5,960,200	5,959,900	300	— %
Commercial ASO	255,300	430,100	(174,800)	(40.6)%
Total Medical Membership	16,857,800	17,079,200	(221,400)	(1.3)%
Total Specialty Membership	4,868,300	5,194,800	(326,500)	(6.3)%

	2023	2022	Change $	Change %
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 78,837	$ 65,591	$ 13,246	20.2 %
Group Medicare Advantage	6,869	7,297	(428)	(5.9)%
Medicare stand-alone PDP	2,189	2,269	(80)	(3.5)%
Total Medicare	87,895	75,157	12,738	16.9 %
Commercial fully-insured	3,527	4,389	(862)	(19.6)%
Specialty benefits	1,007	1,047	(40)	(3.8)%
Medicare Supplement	735	743	(8)	(1.1)%
State-based contracts and other	8,108	6,376	1,732	27.2 %
Total premiums revenue	101,272	87,712	13,560	15.5 %
Commercial ASO	237	300	(63)	(21.0)%
Military services and other	763	550	213	38.7 %
Services revenue	1,000	850	150	17.6 %
Total premiums and services revenue	$ 102,272	$ 88,562	$ 13,710	15.5 %
Income from operations	$ 2,654	$ 3,022	$ (368)	(12.2)%
Benefit ratio	88.0 %	86.6 %		1.4 %
Operating cost ratio	10.2 %	10.4 %		(0.2)%

Income from operations

Insurance segment income from operations decreased $0.4 billion, or 12.2%, from $3.0 billion in the 2022 period to $2.6 billion in the 2023 period primarily due to the same factors impacting 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 843,300 members, or 18.5%, from 4,565,600 members as of December 31, 2022 to 5,408,900 members as of December 31, 2023 primarily due to membership additions associated with the 2023 AEP and continued growth in 2023. The year-over-year growth was further impacted by continued enrollment resulting from special elections, age-ins, and Dual Eligible Special Need Plans, or D-SNP, membership. Individual Medicare Advantage membership includes 871,300 D-SNP members as of December 31, 2023, a net increase of 202,400 members, or 30.3%, from 668,900 members as of December 31, 2022. For the full year 2024, we anticipate a net membership growth in our individual Medicare Advantage offerings of approximately 100,000 members.

Group Medicare Advantage membership decreased 55,500 members, or 9.8%, from 565,100 members as of December 31, 2022 to 509,600 members as of December 31, 2023 reflecting the net loss of certain large accounts partially offset by continued growth in small group accounts. For the full year 2024, we anticipate a net membership growth in our group Medicare Advantage offerings of approximately 45,000 members.

Medicare stand-alone PDP membership decreased 702,200 members, or 19.8%, from 3,551,300 members as of December 31, 2022 to 2,849,100 members as of December 31, 2023 primarily due to continued intensified competition for Medicare stand-alone PDP offerings. For the full year 2024, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of approximately 650,000 members.

State-based contracts and other membership increased 91,500 members, or 8.0%, from 1,137,300 members as of December 31, 2022 to 1,228,800 members as of December 31, 2023 reflecting the impact of membership additions associated with the implementation of the Louisiana and Ohio contracts effective January 2023 and February 2023, respectively, partially offset by ending the suspension of state eligibility redetermination efforts previously enacted as part of the Public Health Emergency. For the full year 2024, we anticipate a net membership growth in our state-based contracts of approximately 250,000 members.

Commercial fully-insured medical membership decreased 217,600 members, or 39.1%, from 556,300 members as of December 31, 2022 to 338,700 members as of December 31, 2023 and commercial ASO medical membership decreased 174,800 members, or 40.6%, from 430,100 members as of December 31, 2022 to 255,300 members as of December 31, 2023. These decreases reflect our planned exit of the Employer Group Commercial Medical Products business, which includes all fully insured, self-funded and Federal Employee Health Benefit medical plans, as well as associated wellness and rewards programs. The exit from this line of business will be phased over the 18 to 24 months following our February 2023 announcement.

Specialty membership decreased 326,500 members, or 6.3%, from 5,194,800 members as of December 31, 2022 to 4,868,300 members as of December 31, 2023 reflecting the decline in membership associated with our Optional Supplemental Benefit products as a result of enhanced mandatory dental and vision supplemental benefits on Medicare Advantage plans. In addition, the decline reflects loss of dental and vision individuals due to terminations as well as loss of dental and vision groups cross-sold with commercial medical products.

Premiums revenue

Insurance segment premiums revenue increased $13.6 billion, or 15.5%, from $87.7 billion in the 2022 period to $101.3 billion in the 2023 period primarily due to individual Medicare Advantage and state-based contracts membership growth and higher per member individual Medicare Advantage premiums. These factors were partially offset by the year-over-year decline in membership associated with group commercial medical, group Medicare Advantage and stand-alone PDP products, as well as the phase-out of COVID-19 sequestration relief in 2022.

Services revenue

Insurance segment services revenue increased $0.15 billion, or 17.6%, from $0.85 billion in the 2022 period to $1 billion in the 2023 period.

Benefits expense

The Insurance segment benefit ratio increased 140 basis points from 86.6% in the 2022 period to 88.0% in the 2023 period primarily due to investments in the benefit design of our Medicare Advantage products for 2023, higher than anticipated Medicare Advantage utilization trends, which further increased in the fourth quarter of 2023, driven by inpatient utilization, primarily for the months of November and December, and non-inpatient trends, predominately in the categories of physician, outpatient surgeries and supplemental benefits, as well as the impact of continued individual Medicare Advantage growth following the 2023 Annual Election Period, or AEP, including a high proportion of age-ins, which typically have a higher benefits expense ratio initially than the average new member. These increases were partially offset by increased individual Medicare Advantage premiums, decreased average unit costs given the additional 20% payment on COVID-19 admissions during the Public Health Emergency, which expired on May 11, 2023, as well as higher favorable prior-period development in 2023. Further, the 2023 ratio continues to reflect a shift in line of business mix, with growth in individual Medicare Advantage and state-based contracts and other membership, which can carry a higher benefits expense ratio.

The Insurance segment benefits expense included $872 million of favorable prior-period medical claims reserve development in the 2023 period and $415 million of favorable prior-period medical claims reserve development in the 2022 period. Prior-period medical claims reserve development decreased the Insurance segment benefit ratio by approximately 90 basis points in the 2023 period and decreased the Insurance segment benefit ratio by approximately 50 basis points in the 2022 period.

Operating costs

The Insurance segment operating cost ratio decreased 20 basis points from 10.4% in the 2022 period to 10.2% in the 2023 period primarily due to scale efficiencies associated with growth in individual Medicare Advantage membership, administrative cost efficiencies as a result of our value creation initiatives, as well as the impact of significantly reduced compensation accruals in 2023 for the annual incentive plan offered to employees across all levels of the company, in accordance with plan requirements, as our 2023 performance was negatively impacted by the previously-discussed higher Medicare Advantage utilization trends. These factors were partially offset by an increase in commissions for brokers related to the individual Medicare Advantage membership growth in 2023, the phase-out of COVID-19 sequestration relief in 2022 and an accrual recorded in 2023 related to certain anticipated litigation expenses.

CenterWell Segment

	2023	2022	Change	
			Dollars	Percentage
		(in millions)		
Revenues:				
Services:				
Home solutions	$ 1,342	$ 2,333	$ (991)	(42.5)%
Pharmacy solutions	849	1,025	(176)	(17.2)%
Primary care	842	568	274	48.2 %
Total services revenue	3,033	3,926	(893)	(22.7)%
Intersegment revenues:				
Home solutions	1,589	553	1,036	187.3 %
Pharmacy solutions	10,451	9,841	610	6.2 %
Primary care	3,332	2,979	353	11.8 %
Total intersegment revenues	15,372	13,373	1,999	14.9 %
Total services and intersegment revenues	$ 18,405	17,299	1,106	6.4 %
Income from operations	$ 1,404	$ 1,291	$ 113	8.8 %
Operating cost ratio	91.2 %	91.5 %		(0.3)%

Income from operations

CenterWell segment income from operations increased $0.1 billion, or 8.8%, from $1.3 billion in the 2022 period to $1.4 billion in the 2023 period.

Services revenue

CenterWell segment services revenue decreased $0.9 billion, or 22.7%, from $3.9 billion in the 2022 period to $3.0 billion in the 2023 period primarily due to the divestiture of the 60% ownership of Gentiva Hospice in August 2022.

Intersegment revenues

CenterWell segment intersegment revenues increased $2.0 billion, or 14.9%, from $13.4 billion in the 2022 period to $15.4 billion in the 2023 period primarily due to individual Medicare Advantage membership growth, which led to higher pharmacy solutions revenues, higher revenues associated with growth in the primary care business, and greater revenues associated with the home solutions business as a result of the expansion of the value-based care home model in 2023 compared to 2022.

Operating costs

The CenterWell segment operating cost ratio decreased 30 basis points from 91.5% in the 2022 period to 91.2% in the 2023 period primarily due to an improving ratio in the primary care business driven by year-over-year medical costs favorability, administrative cost efficiencies related to the pharmacy solutions business, as well as the impact of significantly reduced compensation accruals in 2023 for the annual incentive plan offered to employees across all levels of the company, in accordance with plan requirements, as our 2023 performance was negatively impacted by the previously-discussed higher Medicare Advantage utilization trends. These factors were partially offset by the divestiture of the 60% ownership of Gentiva Hospice in August 2022, which carried a lower operating cost ratio compared to other businesses within the segment, the expansion of the value-based care model within the home solutions business, which carries a higher operating cost ratio compared to the core fee-for-service business, along with growth in Medicare Advantage episodes in the core fee-for-service business, as well as continued investments within the home solutions business to abate the pressures of the current nursing labor environment.

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 CenterWell segment, is generally not restricted by state departments of insurance (or comparable state regulators).

For additional information on our liquidity risk, please refer to Part I, Item 1A, "Risk Factors" of this Form 10-K.

Cash and cash equivalents decreased to $4.7 billion at December 31, 2023 from $5.1 billion at December 31, 2022. The change in cash and cash equivalents for the years ended December 31, 2023, 2022 and 2021 is summarized as follows:

	2023	2022	2021
		(in millions)	
Net cash provided by operating activities	$ 3,981	$ 4,587	$ 2,262
Net cash used in investing activities	(3,492)	(1,006)	(6,556)
Net cash (used in) provided by financing activities	(856)	(1,914)	3,015
(Decrease) increase in cash and cash equivalents	$ (367)	$ 1,667	$ (1,279)

Cash Flow from Operating Activities

Cash flows provided by operations of $4.0 billion in the 2023 period decreased $606 million from cash flows provided by operations of $4.6 billion in the 2022 period primarily due to lower earnings in the 2023 period compared to the 2022 period combined with the unfavorable impact of working capital changes.

The most significant drivers of changes in our working capital are typically the timing of payments of benefits expense and receipts for premiums. 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. For additional information regarding our benefits payable and benefits expense recognition, refer to Note 2 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

The detail of total net receivables was as follows at December 31, 2023, 2022 and 2021:

				Change	
	2023	2022	2021	2023	2022
	(in millions)				
Medicare	$1,426	$1,260	$1,214	$ 166	$ 46
Commercial and other	549	383	579	166	(196)
Military services	148	101	104	47	(3)
Allowance for doubtful accounts	(88)	(70)	(83)	(18)	13
Total net receivables	$2,035	$1,674	$1,814	361	(140)
Reconciliation to cash flow statement:					
Receivables (acquired) disposed				(24)	194
Change in receivables per cash flow statement				$ 337	$ 54

The changes in Medicare receivables for both the 2023 period and the 2022 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 for the 2023 period is primarily related to Medicaid membership growth. The decrease in Commercial and other receivables for 2022 primarily relates to the Gentiva Hospice disposition.

Cash Flow from Investing Activities

During the 2022 period, we completed the sale of a 60% interest of Gentiva Hospice to CD&R for cash proceeds of approximately $2.7 billion, net of cash disposed, including debt repayments from Gentiva Hospice to Humana of $1.9 billion. In connection with the sale we recognized a pre-tax gain, net of transaction costs, of $237 million which was reported as a gain on sale of Gentiva Hospice in the accompanying consolidated statement of income for the year ended December 31, 2022.

During the 2023 period and 2022 period, we acquired various businesses for approximately $233 million and $337 million, respectively, net of cash and cash equivalents received.

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

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our primary care 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. Net capital expenditures, excluding acquisitions, were $794 million, $1.1 billion and $1.3 billion in the 2023, 2022 and 2021 periods, respectively.

Net purchases of investment securities were $2.5 billion, $2.3 billion and $1.1 billion in the 2023, 2022 and 2021 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. Receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk were higher than claim payments by $771 million and $2 billion in the 2023 and 2022 periods, respectively, and 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 in the 2021 period. Our net payable from CMS for subsidies and brand name prescription drug discounts was $1.3 billion at December 31, 2023 compared to a net payable of $540 million at December 31, 2022.

Under our administrative services only TRICARE contract, reimbursements from the federal government exceeded health care costs payments for which we do not assume risk by $57 million and $25 million in the 2023 and 2022 periods, respectively, and health care costs payments for which we do not assume risk exceeded reimbursements from the federal government by $45 million in the 2021 period.

In November 2023, we issued $500 million of 5.750% unsecured senior notes due December 1, 2028 and $850 million of 5.950% unsecured senior notes due March 15, 2034. Our net proceeds, reduced for the underwriters' discounts and commissions paid, were $1.3 billion.

In March 2023, we issued $500 million of 5.700% unsecured senior notes due March 13, 2026 and $750 million of 5.500% unsecured senior notes due March 15, 2053. Our net proceeds, reduced for the underwriters' discounts and commissions paid, were $1.2 billion. We used the net proceeds to repay outstanding amounts under our $500 million Delayed Draw Term Loan. The remaining net proceeds were used for general corporate purposes, which included the repayment of existing indebtedness, including borrowings under our commercial paper program.

In November 2022, we issued $500 million of 5.750% unsecured senior notes due March 1, 2028 and $750 million of 5.875% unsecured senior notes due March 1, 2033. Our net proceeds, reduced for the underwriters' discounts and commissions paid, were $1.2 billion.

In March 2022, we issued $750 million of 3.700% unsecured senior notes due March 23, 2029. Our net proceeds, reduced for the underwriters' discounts and commissions paid, were $744 million.

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 $3.0 billion.

In August 2023, we entered into a Rule 10b5-1 Repurchase Plan to repurchase a portion of our $750 million aggregate principal amount of 1.350% senior notes maturing in February 2027, our $600 million aggregate principal amount of 3.950% senior notes maturing in March 2027, our $750 million aggregate principal amount of 3.700% senior notes maturing in March 2029, and our $500 million aggregate principal amount of 3.125% senior notes maturing in August 2029 during the period beginning on August 7, 2023 and ending on November 15, 2023. For the year ended December 31, 2023, we repurchased $339 million principal amount of these senior notes for approximately $310 million cash.

In March 2023, we entered into a Rule 10b5-1 Repurchase Plan to repurchase a portion of our $1.5 billion aggregate principal amount of 0.650% senior notes maturing in August 2023 and our $600 million aggregate principal amount of 3.850% senior notes maturing in October 2024 during the period beginning on March 13, 2023 and ending on July 21, 2023. For the year ended December 31, 2023, we repurchased $361 million principal amount

of these senior notes for approximately $358 million cash. We repaid the remaining $1.2 billion aggregate principal amount of our 0.650% senior notes due on their maturity date of August 3, 2023.

We repaid $600 million aggregate principal amount of our 3.150% senior notes due on their maturity date of December 1, 2022 and $400 million aggregate principal amount of our 2.900% senior notes due on their maturity date of December 15, 2022.

We entered into a commercial paper program in October 2014. Net proceeds from issuance of commercial paper were $211 million in 2023 and the maximum principal amount outstanding at any one time during 2023 was $3.3 billion. Net repayments from the issuance of commercial paper were $376 million in 2022 and the maximum principal amount outstanding at any one time during 2022 was $1.5 billion. 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.

We received a short-term cash advance of $100 million from FHLB with certain of our marketable securities as collateral and subsequently repaid the outstanding balance in December 2023.

In August 2022, we repaid the $2.0 billion October 2021 Term Loan Agreement without a prepayment penalty due.

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 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 Gentiva Hospice.

We repurchased common shares for $1.6 billion, $2.1 billion and $79 million in 2023, 2022 and 2021, respectively, under share repurchase plans authorized by the Board of Directors and in connection with employee stock plans.

We paid dividends to stockholders of $431 million in 2023, $392 million in 2022, and $354 million in 2021.

Future Sources and Uses of Liquidity

Dividends

For a detailed discussion of dividends to stockholders, please refer to Note 16 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

Stock Repurchases

For a detailed discussion of stock repurchases, please refer to Note 16 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

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 audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

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, 2023 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa2 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $250 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $1 million, up to a maximum 100 basis points, or annual interest expense by $3 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company decreased to $0.5 billion at December 31, 2023 from $0.9 billion at December 31, 2022. This decrease primarily reflects common stock repurchases, repayment of maturing senior notes, capital expenditures, capital contributions to certain subsidiaries, cash dividends to shareholders and acquisitions, partially offset by net proceeds from the senior notes, dividends from insurance subsidiaries, and cash from certain non-insurance subsidiaries within our CenterWell segment. Our use of operating cash derived from our non-insurance subsidiaries, such as our CenterWell segment, is generally not restricted by regulators. Our regulated insurance subsidiaries paid dividends to our parent company of $1.8 billion in 2023, $1.3 billion in 2022, and $1.6 billion in 2021. 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 2024 is approximately $1.1 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

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 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

Off-Balance Sheet Arrangements

As of December 31, 2023, 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 audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 17 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, military services, and Medicaid and state-based contracts, please refer to Note 17 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

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. 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 audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

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, 2023 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)		
0.90%	$707	4.50%	$750
0.80%	$628	4.25%	$709
0.70%	$550	4.00%	$667
0.60%	$471	3.75%	$625
0.50%	$393	3.50%	$584
0.40%	$314	3.25%	$542
0.30%	$236	3.00%	$500
0.20%	$157	2.75%	$459
0.10%	$79	2.50%	$417
0.05%	$39	2.25%	$375
0.03%	$20	2.00%	$333

(a) Reflects estimated potential changes in benefits payable at December 31, 2023 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, 2023 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 audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K for information about incurred and paid claims development as of December 31, 2023 as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2023	2022	2021
		(in millions)	
Balances at January 1	$ 9,264	$ 8,289	$ 8,143
Acquisitions	62	—	42
Incurred related to:			
Current year	89,266	76,105	70,024
Prior years	(872)	(415)	(825)
Total incurred	88,394	75,690	69,199
Paid related to:			
Current year	(79,545)	(67,287)	(62,149)
Prior years	(7,934)	(7,428)	(6,946)
Total paid	(87,479)	(74,715)	(69,095)
Balances at December 31	$ 10,241	$ 9,264	$ 8,289

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					
	2023		2022		2021	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (586)	(0.7)%	$ (387)	(0.6)%	$ (361)	(3.3)%
Completion factors	(286)	(0.4)%	(28)	— %	(464)	(0.9)%
Total	$ (872)		$ (415)		$ (825)	

(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 $872 million in 2023, $415 million in 2022, and $825 million in 2021.

The favorable medical claims reserve development for 2023, 2022, and 2021 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. The favorable development recognized in 2023 and 2021 primarily resulted from trend factors developing more favorably than originally expected as well as for 2021 completion factors developing faster than expected. The favorable development recognized in 2022 resulted primarily from completion factors remaining largely unchanged, resulting in lower overall development as compared to 2023 and 2021.

Our favorable development for each of the years presented above is discussed further in Note 11 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

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, 2023 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 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 account for certain demographic characteristics and health status of our enrolled members. 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, collected from providers, to calculate the health status-related risk-adjusted premium payment to MA plans, which CMS further adjusts for coding pattern differences between the health plans and the government fee-for-service (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 health status-adjusted 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. For additional information, refer to Note 17 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" and Part I, Item 1A, "Risk Factors" of this Form 10-K.

Investment Securities

Investment securities totaled $17.0 billion, or 36% of total assets at December 31, 2023, and $14.3 billion, or 33% of total assets at December 31, 2022. The investment portfolio was primarily comprised of debt securities, detailed below, at December 31, 2023 and December 31, 2022. The fair value of investment securities were as follows at December 31, 2023 and 2022:

	12/31/2023	Percentage of Total	12/31/2022	Percentage of Total
	(dollars in millions)			
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 2,667	15.7 %	$ 1,039	7.3 %
Mortgage-backed securities	3,522	20.7 %	3,230	22.6 %
Tax-exempt municipal securities	858	5.0 %	728	5.1 %
Mortgage-backed securities:				
Residential	400	2.4 %	401	2.8 %
Commercial	1,345	7.9 %	1,399	9.8 %
Asset-backed securities	1,771	10.4 %	1,731	12.1 %
Corporate debt securities	6,445	37.9 %	5,726	40.2 %
Total debt securities	17,008	100.0 %	14,254	100.0 %
Common stock	—	— %	7	— %
Total investment securities	$ 17,008	100.0 %	$ 14,261	100.0 %

Approximately 97% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2023. Most of the debt securities that were below investment-grade were rated B+, 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 approximately 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, 2023:

	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	$ 1,899	$ (12)	$ 431	$ (39)	$ 2,330	$ (51)
Mortgage-backed securities	958	(12)	2,269	(413)	3,227	(425)
Tax-exempt municipal securities	160	(1)	523	(21)	683	(22)
Mortgage-backed securities:						
Residential	—	—	373	(66)	373	(66)
Commercial	18	—	1,303	(126)	1,321	(126)
Asset-backed securities	120	(1)	1,364	(43)	1,484	(44)
Corporate debt securities	466	(2)	4,783	(592)	5,249	(594)
Total debt securities	$ 3,621	$ (28)	$ 11,046	$ (1,300)	$ 14,667	$ (1,328)

Under the current expected credit losses model, or CECL, 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, 2023 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, 2023, 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, 2023, 2022 or 2021.

Goodwill, Indefinite-lived and Long-lived Assets

At December 31, 2023, goodwill, indefinite-lived and other long-lived assets represented 30% of total assets and 87% of total stockholders' equity, compared to 33% and 92%, respectively, at December 31, 2022. The decrease in goodwill, indefinite-lived and other long-lived assets as a percentage of total assets is primarily attributable to the increase in investment securities.

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 primary care reporting units, which accounted for $4.4 billion and $1.2 billion of goodwill, respectively. Impairment tests completed for 2023, 2022, and 2021 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 $1.4 billion at December 31, 2023. 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 2023 and 2022 did not result in material impairment losses. These charges reflect the amount by which the carrying value exceeded its estimated fair value. Impairment tests completed for 2021 did not result in an impairment loss. The fair values of the assets were measured using Level 3 inputs, such as projected revenues and operating cash flows.

Long-lived assets consist of property and equipment and other definite-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. Other than the impairment charges as described in Footnote 2 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K, there were no other 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, 2023 or December 31, 2022.

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, 2023. Our net unrealized position increased $0.4 billion from a net unrealized loss position of $1.7 billion at December 31, 2022 to a net unrealized loss position of $1.3 billion at December 31, 2023. At December 31, 2023, we had gross unrealized losses of $1.3 billion 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 2023 and 2022. 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 3.0 years as of December 31, 2023 and 3.2 years as of December 31, 2022. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the December 31, 2023 fair value of our securities by approximately $656 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, 2023 and 2022. 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 one time, have changed between 100 and 200 basis points four times, and have changed by less than 100 basis points five times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2023						
Investment income (a)	$ (338)	$ (222)	$ (111)	$ 111	$ 224	$ 336
Interest expense (b)	129	86	43	(43)	(86)	(129)
Pretax	$ (209)	$ (136)	$ (68)	$ 68	$ 138	$ 207
As of December 31, 2022						
Investment income (a)	$ (276)	$ (184)	$ (92)	$ 93	$ 186	$ 281
Interest expense (b)	56	37	19	(19)	(37)	(57)
Pretax	$ (220)	$ (147)	$ (73)	$ 74	$ 149	$ 224

(a) As of December 31, 2023, none of our investments had interest rates below 1%. As of December 31, 2022, some of our investments had interest rates below 1%, so the assumed hypothetical change in pretax earnings does not reflect the full 1% point reduction.

(b) The interest rate under our senior notes, which represent 93% of total debt, is fixed, unaffected by changes in interest rates. We did not have any variable rate term loans at December 31, 2023 and had $0.5 billion of variable rate term loans at December 31, 2022 which were used to fund the August 2021 KAH acquisition. There were no borrowings outstanding under the credit agreement at December 31, 2023 or December 31, 2022. There was $871 million and $595 million outstanding under our commercial paper program at December 31, 2023 and 2022, respectively. As of December 31, 2023 and December 31, 2022, our interest rates under our commercial paper program was not less than 1%.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2023	2022
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 4,694	$ 5,061
Investment securities	16,626	13,881
Receivables, net of allowances of $88 in 2023 and $70 in 2022	2,035	1,674
Other current assets	6,631	5,567
Total current assets	29,986	26,183
Property and equipment, net	3,030	3,221
Long-term investment securities	382	380
Goodwill	9,550	9,142
Equity method investments	740	749
Other long-term assets	3,377	3,380
Total assets	$ 47,065	$ 43,055
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 10,241	$ 9,264
Trade accounts payable and accrued expenses	6,569	5,238
Book overdraft	353	298
Unearned revenues	266	286
Short-term debt	1,443	2,092
Total current liabilities	18,872	17,178
Long-term debt	10,213	9,034
Other long-term liabilities	1,662	1,473
Total liabilities	30,747	27,685
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; 198,690,082 shares issued at December 31, 2023 and 198,666,598 shares issued at December 31, 2022	33	33
Capital in excess of par value	3,346	3,246
Retained earnings	27,540	25,492
Accumulated other comprehensive loss	(999)	(1,304)
Treasury stock, at cost, 76,465,862 shares at December 31, 2023 and 73,691,955 shares at December 31, 2022	(13,658)	(12,156)
Total stockholders' equity	16,262	15,311
Noncontrolling interests	56	59
Total equity	16,318	15,370
Total liabilities and equity	$ 47,065	$ 43,055

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

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2023	2022	2021
	(in millions, except per share results)		
Revenues:			
Premiums	$ 101,272	$ 87,712	$ 79,822
Services	4,033	4,776	3,055
Investment income	1,069	382	187
Total revenues	106,374	92,870	83,064
Operating expenses:			
Benefits	88,394	75,690	69,199
Operating costs	13,188	12,671	10,121
Depreciation and amortization	779	709	596
Total operating expenses	102,361	89,070	79,916
Income from operations	4,013	3,800	3,148
Gain on sale of Gentiva Hospice	—	(237)	—
Interest expense	493	401	326
Other expense (income), net	137	68	(532)
Income before income taxes and equity in net earnings	3,383	3,568	3,354
Provision for income taxes	836	762	485
Equity in net (losses) earnings	(63)	(4)	65
Net income	$ 2,484	$ 2,802	$ 2,934
Net loss (income) attributable to noncontrolling interests	5	4	(1)
Net income attributable to Humana	$ 2,489	$ 2,806	$ 2,933
Basic earnings per common share	$ 20.09	$ 22.20	$ 22.79
Diluted earnings per common share	$ 20.00	$ 22.08	$ 22.67

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,		
	2023	2022	2021
		(in millions)	
Net income attributable to Humana	$ 2,489	$ 2,806	$ 2,933
Other comprehensive income (loss):			
Change in gross unrealized investment gains (losses)	372	(1,819)	(356)
Effect of income taxes	(85)	418	81
Total change in unrealized investment gains (losses), net of tax	287	(1,401)	(275)
Reclassification adjustment for net realized losses (gains) included in investment income	25	72	(103)
Effect of income taxes	(7)	(17)	23
Total reclassification adjustment, net of tax	18	55	(80)
Other comprehensive income (loss), net of tax	305	(1,346)	(355)
Comprehensive income attributable to equity method investments	—	—	6
Comprehensive income attributable to Humana	$ 2,794	$ 1,460	$ 2,584

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

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity	Noncontrolling Interests	Total Equity
	Issued Shares	Amount							
	(dollars in millions, share amounts in thousands)								
Balances, December 31, 2020	198,649	33	2,705	20,517	391	(9,918)	13,728	—	13,728
Net income				2,933			2,933	1	2,934
Acquisition								22	22
Other comprehensive loss					(349)		(349)		(349)
Common stock repurchases	—		262			(341)	(79)		(79)
Dividends and dividend equivalents			—	(364)			(364)		(364)
Stock-based compensation			180				180		180
Restricted stock unit vesting	—	—	(81)			81	—		—
Stock option exercises	—	—	16			15	31		31
Balances, December 31, 2021	198,649	33	3,082	23,086	42	(10,163)	16,080	23	16,103
Net income				2,806			2,806	(4)	2,802
Distribution to noncontrolling interest holders, net							—	(1)	(1)
Sale of Gentiva Hospice							—	(11)	(11)
Acquisition							—	52	52
Other comprehensive loss					(1,346)		(1,346)		(1,346)
Common stock repurchases	—		—			(2,096)	(2,096)		(2,096)
Dividends and dividend equivalents			—	(400)			(400)		(400)
Stock-based compensation			216				216		216
Restricted stock unit vesting	18	—	(78)			78	—		—
Stock option exercises	—	—	26			25	51		51
Balances, December 31, 2022	198,667	33	3,246	25,492	(1,304)	(12,156)	15,311	59	15,370
Net income				2,489			2,489	(5)	2,484
Distribution from noncontrolling interest holders, net							—	7	7
Acquisition							—	(5)	(5)
Other comprehensive income					305		305		305
Common stock repurchases	—		—			(1,586)	(1,586)		(1,586)
Dividends and dividend equivalents			—	(441)			(441)		(441)
Stock-based compensation			175				175		175
Restricted stock unit vesting	23	—	(80)			80	—		—
Stock option exercises	—	—	5			4	9		9
Balances, December 31, 2023	198,690	33	3,346	27,540	(999)	(13,658)	16,262	56	16,318

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,		
	2023	2022	2021
		(in millions)	
Cash flows from operating activities			
Net income	$ 2,484	$ 2,802	$ 2,934
Adjustments to reconcile net income to net cash provided by operating activities:			
Gain on sale of Gentiva Hospice	—	(237)	—
Loss on investment securities, net	54	205	130
Gain on Kindred at Home equity method investment	—	—	(1,129)
Equity in net losses (earnings)	63	4	(65)
Stock-based compensation	175	216	180
Depreciation	850	749	640
Amortization	67	96	73
Impairment of property and equipment	206	248	—
Impairment of intangible assets	55	—	—
Deferred income taxes	(167)	(100)	15
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(337)	(54)	(280)
Other assets	(1,318)	(463)	(491)
Benefits payable	915	975	104
Other liabilities	841	44	176
Unearned revenues	(20)	32	(65)
Other, net	113	70	40
Net cash provided by operating activities	3,981	4,587	2,262
Cash flows from investing activities			
Proceeds from sale of Gentiva Hospice, net	—	2,701	—
Acquisitions, net of cash and cash equivalents acquired	(233)	(337)	(4,187)
Purchases of property and equipment	(1,004)	(1,137)	(1,342)
Proceeds from sale of property and equipment	210	17	26
Purchases of investment securities	(7,552)	(6,049)	(7,197)
Proceeds from maturities of investment securities	1,292	1,365	2,597
Proceeds from sales of investment securities	3,795	2,434	3,547
Net cash used in investing activities	(3,492)	(1,006)	(6,556)
Cash flows from financing activities			
Receipts (withdrawals) from contract deposits, net	828	1,993	(306)
Proceeds from issuance of senior notes, net	2,544	1,982	2,984
Repayment of senior notes	(1,832)	(1,000)	—
Proceeds (repayments) from issuance of commercial paper, net	211	(376)	352
Proceeds from short-term borrowings	100	—	—
Repayment of short-term borrowings	(100)	—	—
Proceeds from term loan	—	—	2,500
Repayment of term loan	(500)	(2,000)	(2,078)
Debt issue costs	(7)	(6)	(31)
Common stock repurchases	(1,573)	(2,096)	(79)
Dividends paid	(431)	(392)	(354)
Change in book overdraft	55	(28)	6
Other, net	(151)	9	21
Net cash (used in) provided by financing activities	(856)	(1,914)	3,015
(Decrease) increase in cash and cash equivalents	(367)	1,667	(1,279)
Cash and cash equivalents at beginning of period	5,061	3,394	4,673
Cash and cash equivalents at end of period	$ 4,694	$ 5,061	$ 3,394

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW—(Continued)

	For the year ended December 31,		
	2023	2022	2021
Supplemental cash flow disclosures:		(in millions)	
Interest payments	$ 394	$ 354	$ 285
Income tax payments, net	$ 997	$ 758	$ 227
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 462	$ 460	$ 9,804
Less: Fair value of liabilities assumed	(234)	(70)	(3,235)
Less: Noncontrolling interests acquired	5	(53)	(22)
Less: Remeasured existing Kindred at Home equity method investment	—	—	(2,360)
Cash paid for acquired businesses, net of cash acquired	$ 233	$ 337	$ 4,187

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 committed to putting health first – for our teammates, our customers, and our company. Through our Humana insurance services, and our CenterWell health care services, we make it easier for the millions of people we serve to achieve their best health – delivering the care and service they need, when they need it. These efforts are leading to a better quality of life for people with Medicare, Medicaid, families, individuals, military service personnel, and communities at large. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 84% of our total premiums and services revenue from contracts with the federal government in 2023, including 14% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

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

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill 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.

Value Creation Initiatives and Impairment Charges

In order to create capacity to fund growth and investment in our Medicare Advantage business and further expansion of our healthcare services capabilities beginning in 2022, we committed to drive additional value for the enterprise through cost saving, productivity initiatives, and value acceleration from previous investments. As a result of these initiatives, we recorded charges of $436 million and $473 million in 2023 and 2022, respectively, within operating costs in the consolidated statements of income. These charges were recorded at the corporate level and not allocated to the segments. We expect to incur additional charges through the end of 2024.

The value creation initiative charges primarily relate to $237 million and $248 million in asset impairments in 2023 and 2022, respectively, as well as $199 million and $116 million in severance charges in connection with workforce optimization in 2023 and 2022, respectively. The remainder of the 2022 charges primarily relate to external consulting fees.

During 2023, we also recorded severance charges of $70 million within operating costs in our consolidated statement of income as a result of our exit from the Employer Group Commercial Medical Products business and impairment charges of $91 million, including $55 million relating to indefinite-lived intangibles. The indefinite-

lived intangibles impairment charges were included within operating costs in our consolidated statement of income with the remaining impairment charges included within investment income.

COVID-19

The emergence and spread of the novel coronavirus, or COVID-19, beginning in the first quarter of 2020 has impacted our business. Initially during periods of increased incidences of COVID-19, a reduction in non-COVID-19 hospital admissions for non-emergent and elective medical care resulted in lower overall healthcare system utilization. At the same time, COVID-19 treatment and testing costs increased utilization. During 2022, we experienced lower overall utilization of the healthcare system than anticipated, as the reduction in COVID-19 utilization following the increased incidence associated with the Omicron variant outpaced the increase in non-COVID-19 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 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 2021.

The COVID-19 National Emergency declared in 2020 was terminated on April 10, 2023 and the Public Health Emergency expired on May 11, 2023.

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, as well as our equity securities, 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, are classified as long-term assets. For the purpose of determining realized gross gains and losses for debt securities sold, that 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 in other comprehensive income or loss as a component of stockholders' equity 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.

Under the current expected credit losses model, or CECL, 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, net in our consolidated statements of cash flows.

	2023	2022	2021
		(in millions)	
Part D subsidy/discount payments	$ (17,582)	$ (16,530)	$ (14,889)
Part D subsidy/discount reimbursements	18,353	18,498	14,628
Net reimbursements (payments)	$ 771	$ 1,968	$ (261)

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. For additional information 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, refer to Note 7 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in this Form 10-K.

Patient services revenue

Patient services include services related to pharmacy solutions, primary care, and home solutions and other services and capabilities to promote wellness and advance population health.

For our pharmacy solutions business, external pharmacy revenues include the cost of pharmaceuticals (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through our CenterWell Pharmacy (our mail-order pharmacy business), CenterWell Specialty Pharmacy, and retail pharmacies jointly located within CenterWell Senior Primary Care clinics. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Services revenues related to product revenues from dispensing prescriptions are recorded when the prescription or product is shipped.

Our primary care business recognizes revenues for certain value-based arrangements. Under these value-based arrangements, we enter into agreements with health plans to stand ready to deliver, integrate, direct and control the administration and management of certain health care services for our patients. In exchange, we receive a premium that is typically paid on a per-member per-month basis. These value-based arrangements represent a single performance obligation where revenues are recognized in the period in which we are obligated to provide integrated health care services to our patients. Fee-for-service revenue is recognized at agreed upon rates, net of contractual allowances, as the performance obligation is completed on the date of service.

For our home solutions businesses, revenues include net patient services revenue recorded based upon established billing rates, net of contractual allowances, discounts, or other implicit price concessions, and are recognized as performance obligations are satisfied, which is in the period services are rendered.

For the year ended December 31, 2023, 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 is 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, net in our consolidated statements of cash flows.

	2023	2022	2021
		(in millions)	
Health care cost payments	$ (7,073)	$ (7,110)	$ (6,943)
Health care cost reimbursements	7,130	7,135	6,898
Net reimbursements (payments)	$ 57	$ 25	$ (45)

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, 2023 and 2022, accounts receivable related to services were $357 million and $291 million, respectively. For the years ended December 31, 2023, 2022 and 2021, 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, 2023 and 2022.

Other Current Assets

Other current assets include amounts associated with Medicare Part D, 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 $2.3 billion and $2.0 billion at December 31, 2023 and 2022, respectively. For additional information regarding amounts associated with Medicare Part D, refer to Note 7 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in this Form 10-K.

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 in our consolidated income statements. Certain costs related to the development or purchase of internal-use software are capitalized. Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years for equipment, 3 to 5 years for computer software, and 10 to 20 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

We periodically review long-lived assets, including property and equipment and other 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.

For additional information regarding our equity method investments, refer to Note 4 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in this Form 10-K.

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. 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 primary care reporting units, which accounted for $4.4 billion and $1.2 billion of goodwill, respectively. Impairment tests completed for 2023, 2022, and 2021 did not result in an impairment loss.

Intangible assets with indefinite lives 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, 2023 and December 31, 2022. For additional information regarding our acquisition of KAH, refer to Note 3 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in this Form 10-K. 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 2023 and 2022 did not result in material impairment losses. These charges reflect the amount by which the carrying value exceeded its estimated fair value. Impairment tests completed for 2021 did not result in an impairment loss. The fair values of the assets were measured using Level 3 inputs, such as projected revenues and operating cash flows.

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 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. 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. For additional information regarding reinsurance, refer to Note 19 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in this Form 10-K.

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 businesses within our Insurance and CenterWell segments, 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.

For additional information regarding our stock-based compensation plans, refer to Note 14 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in this Form 10-K.

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.

For additional information regarding our earnings per share, refer to Note 15 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in this Form 10-K.

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

Recently Adopted Accounting Pronouncements

In November 2020, the FASB issued Accounting Standards Update No. 2020-11, Financial Services—Insurance (Topic 944): Effective Date and Early Application ("ASU 2020-11"). The amendments in ASU 2020-11 make changes to the effective date and early application of Accounting Standards Update No. 2018-12, Financial Services—Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts ("ASU 2018-12"), which was issued in November 2018. The amendments in ASU 2020-11 extended the original effective date by one year, and now the amendments are required for our interim and annual reporting periods beginning after December 15, 2022. The new guidance relates 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 represents less than 1% of consolidated premiums and services revenue, became effective for us

beginning January 1, 2023 and was applied to contracts in force on the basis of their existing carrying value amounts at the beginning of the earliest period presented. The adoption of the new standard in 2023 did not have a material impact on our consolidated results of operations, financial position or cash flows.

Accounting Pronouncements Effective in Future Periods

In December 2023, the FASB issued Accounting Standards Update No. 2023-07, Segment Reporting — Improvements to Reportable Segment Disclosures. The new guidance requires incremental disclosures related to a public entity's reportable segments but does not change the definition of a segment, the method for determining segments, or the criteria for aggregating operating segments into reportable segments. The new guidance requires a public entity to disclose its significant segment expense categories and amounts for each reportable segment. The new guidance will be effective for us beginning with our annual 2024 year-end financial statements. We are currently evaluating the impact on our segment information footnote disclosures.

In December 2023, the FASB issued Accounting Standards Update No. 2023-09 — Income Taxes (Topic 740): Improvements to Income Tax Disclosures. The new guidance requires significant additional disclosures about income taxes, primarily focused on the disclosure of income taxes paid and the rate reconciliation table. The new guidance requires prospective application (with retrospective application permitted). The new guidance will be effective for us beginning with our annual 2025 year-end financial statements, with early adoption permitted. We are currently evaluating the impact on our income tax footnote disclosures.

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

3. ACQUISITIONS AND DIVESTITURES

On August 11, 2022, we completed the sale of a 60% interest in Gentiva (formerly Kindred) Hospice to Clayton, Dubilier & Rice, or CD&R, for cash proceeds of approximately $2.7 billion, net of cash disposed, including debt repayments from Gentiva Hospice to Humana of $1.9 billion. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $237 million which was reported as a gain on sale of Gentiva Hospice in the accompanying consolidated statement of income for the year ended December 31, 2022.

In June 2022, we classified Gentiva Hospice as held-for-sale and aggregated Gentiva Hospice's assets and liabilities separately on the balance sheet. The assets, liabilities and noncontrolling interest disposed of on August 11, 2022 were as follows:

		(in millions)
Cash and cash equivalents	$	73
Receivables, net of allowances		194
Other current assets		20
Property and equipment, net		44
Goodwill		2,331
Other assets		960
Total assets	$	3,622
Trade accounts payable and accrued expenses	$	245
Other long-term liabilities		285
Total liabilities	$	530
Noncontrolling interest	$	11

Other assets included $866 million identifiable intangibles consisting of Medicare licenses and CON.

Prior to the sale of a 60% interest in Gentiva Hospice on August 11, 2022, as discussed above, Gentiva Hospice revenues and pretax earnings through the date of sale for the year ended December 31, 2022, were $958 million and $150 million, respectively.

On August 17, 2021, we acquired the remaining 60% interest in Kindred at Home, or KAH, from TPG Capital and Welsh, Carson, Anderson & Stowe, or WCAS, two private equity funds, for an enterprise value of $8.2 billion, which included 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" in the accompanying consolidated statement of income for the year ended December 31, 2021. 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.

During 2023, 2022, and 2021, 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 2023, 2022 and 2021 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. Our share of income or loss was reported as equity in net (losses) earnings in our consolidated statements of income.

We completed the sale of a 60% interest in Gentiva Hospice on August 11, 2022 and we account for our remaining minority ownership in Gentiva Hospice using the equity method of accounting. At December 31, 2023 and 2022 we owned 35% and 40%, respectively. This investment was reflected in equity method investments in our December 31, 2023 and 2022 consolidated balance sheets, with our share of income or loss reported as equity in net (losses) earnings in our consolidated statements of income.

The summarized balance sheets and statements of income at December 31, 2023 and 2022 of Gentiva Hospice were as follows:

Balance sheet	**December 31, 2023**	**December 31, 2022**
	(in millions)	
Current assets	$ 415	$ 297
Non-current assets	4,260	3,577
Current liabilities	409	269
Non-current liabilities	2,719	2,219
Shareholders' equity	1,547	1,386

Statements of income	**For the year ended December 31, 2023**	**August 11, 2022 through December 31, 2022**
	(in millions)	
Revenues	$ 1,850	$ 654
Expenses	1,873	652
Net income	(23)	2

Other equity method investments

In 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. In May 2022, we established a second strategic partnership with WCAS to develop additional centers between 2023 and 2025. As of December 31, 2023, there were 108 primary care clinics operating under the partnership and we have capacity to open or acquire up to approximately 60 additional centers through the existing partnership agreements. In addition, the agreements include 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 2 to 9 years. We have the option to purchase the first cohort of clinics in 2025 for approximately $550 million to $650 million based on current projections. All existing cohorts can be called by us from 2025 to 2030 and could require $2.0 billion to $3.0 billion based on current projections. These estimates are dependent on multiple factors including the actual timing of when the put or call options are exercised, expected revenue growth at each center within the respective cohort and future capital contributions, among other factors. For additional information on inputs relevant to these put and call options, refer to Note 6 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

We have several individually immaterial equity method investments, including our strategic partnership with WCAS as described above, included within equity method investments in our consolidated balance sheets as of December 31, 2023 and 2022 with our share of income or loss reported as equity in net (losses) earnings in our consolidated statements of income for the years ended December 31, 2023, 2022 and 2021.

5. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2023 and 2022, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
	(in millions)			
December 31, 2023				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 2,717	$ 1	$ (51)	$ 2,667
Mortgage-backed securities	3,946	1	(425)	3,522
Tax-exempt municipal securities	879	1	(22)	858
Mortgage-backed securities:				
Residential	465	1	(66)	400
Commercial	1,471	—	(126)	1,345
Asset-backed securities	1,813	2	(44)	1,771
Corporate debt securities	7,011	28	(594)	6,445
Total debt securities	$ 18,302	$ 34	$ (1,328)	17,008
Common stock				—
Total investment securities				$ 17,008
December 31, 2022				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 1,093	$ 1	$ (55)	$ 1,039
Mortgage-backed securities	3,697	4	(471)	3,230
Tax-exempt municipal securities	765	—	(37)	728
Mortgage-backed securities:				
Residential	477	—	(76)	401
Commercial	1,554	—	(155)	1,399
Asset-backed securities	1,809	1	(79)	1,731
Corporate debt securities	6,551	3	(828)	5,726
Total debt securities	$ 15,946	$ 9	$ (1,701)	14,254
Common stock				7
Total investment securities				$ 14,261

We own certain corporate debt securities of Gentiva Hospice. The book value and fair value are $379 million and $398 million, respectively, at December 31, 2023. The book value and fair value were $280 million and $278 million, respectively, at December 31, 2022.

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, 2023 and 2022, 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, 2023						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 1,899	$ (12)	$ 431	$ (39)	$ 2,330	$ (51)
Mortgage-backed securities	958	(12)	2,269	(413)	3,227	(425)
Tax-exempt municipal securities	160	(1)	523	(21)	683	(22)
Mortgage-backed securities:						
Residential	—	—	373	(66)	373	(66)
Commercial	18	—	1,303	(126)	1,321	(126)
Asset-backed securities	120	(1)	1,364	(43)	1,484	(44)
Corporate debt securities	466	(2)	4,783	(592)	5,249	(594)
Total debt securities	$ 3,621	$ (28)	$ 11,046	$ (1,300)	$ 14,667	$ (1,328)
December 31, 2022						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 512	$ (5)	$ 397	$ (50)	$ 909	$ (55)
Mortgage-backed securities	1,231	(104)	1,683	(367)	2,914	(471)
Tax-exempt municipal securities	64	(2)	615	(36)	679	(38)
Mortgage-backed securities:						
Residential	124	(16)	274	(60)	398	(76)
Commercial	243	(13)	1,157	(142)	1,400	(155)
Asset-backed securities	620	(32)	1,011	(46)	1,631	(78)
Corporate debt securities	1,625	(98)	3,825	(730)	5,450	(828)
Total debt securities	$ 4,419	$ (270)	$ 8,962	$ (1,431)	$ 13,381	$ (1,701)

Approximately 97% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2023. Most of the debt securities that were below investment-grade were rated B+, 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 approximately 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 1,560 positions out of a total of approximately 2,060 positions at December 31, 2023. All issuers of debt securities we own that were trading at an unrealized loss at December 31, 2023 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, 2023, 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, 2023, 2022 or 2021.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2023, 2022, and 2021:

	2023	2022	2021
		(in millions)	
Gross gains on investment securities	$ 46	$ 62	$ 219
Gross losses on investment securities	(101)	(144)	(8)
Gross gains on equity securities	1	51	23
Gross losses on equity securities	—	(174)	(364)
Net recognized losses on investment securities	$ (54)	$ (205)	$ (130)

The gains and losses related to equity securities for the years ended December 31, 2023, 2022 and 2021 was as follows:

	2023	2022	2021
		(in millions)	
Net gains (losses) recognized on equity securities during the period	$ 1	$ (123)	$ (341)
Less: Net gains (losses) recognized on equity securities sold during the period	1	(105)	(13)
Unrealized losses recognized on equity securities still held at the end of the period	$ —	$ (18)	$ (328)

The contractual maturities of debt securities available for sale at December 31, 2023, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 1,243	$ 1,239
Due after one year through five years	5,279	5,112
Due after five years through ten years	2,936	2,657
Due after ten years	1,149	962
Mortgage and asset-backed securities	7,695	7,038
Total debt securities	$ 18,302	$ 17,008

6. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2023 and 2022, respectively, for financial assets measured at fair value on a recurring basis:

	Fair Value	Fair Value Measurements Using: Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2023				
Cash equivalents	$ 4,582	$ 4,582	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	2,667	—	2,667	—
Mortgage-backed securities	3,522	—	3,522	—
Tax-exempt municipal securities	858	—	858	—
Mortgage-backed securities:				
Residential	400	—	396	4
Commercial	1,345	—	1,345	—
Asset-backed securities	1,771	—	1,733	38
Corporate debt securities	6,445	—	6,269	176
Total debt securities	17,008	—	16,790	218
Common stock	—	—	—	—
Total invested assets	$ 21,590	$ 4,582	$ 16,790	$ 218
December 31, 2022				
Cash equivalents	$ 4,832	$ 4,832	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	1,039	—	1,039	—
Mortgage-backed securities	3,230	—	3,230	—
Tax-exempt municipal securities	728	—	728	—
Mortgage-backed securities:				
Residential	401	—	401	—
Commercial	1,399	—	1,399	—
Asset-backed securities	1,731	—	1,731	—
Corporate debt securities	5,726	—	5,625	101
Total debt securities	14,254	—	14,153	101
Common stock	7	7	—	—
Total invested assets	$ 19,093	$ 4,839	$ 14,153	$ 101

Our Level 3 assets had fair values of $218 million, or 1.0% of total invested assets, and $101 million, or 0.5% of total invested assets, at December 31, 2023 and 2022, respectively. During the years ended December 31, 2023 and 2022, 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, 2023	For the year ended December 31, 2022
	Private Placements	
	(in millions)	
Beginning balance at January 1	$ 101	$ 68
Total gains or losses:		
Realized in earnings	—	—
Unrealized in other comprehensive income	3	(14)
Purchases	115	47
Sales	—	—
Settlements	—	—
Transfers Out	(8)	—
Transfers In	7	—
Balance at December 31	$ 218	$ 101

Interest Rate Swaps

During 2023, we entered into interest-rate swap agreements with major financial institutions to convert our interest-rate exposure on our $750 million of 5.875% senior notes, our $750 million of 5.500% senior notes, our $500 million of 3.950% senior notes and our $850 million of 5.950% from fixed rates to variable rates to align interest costs more closely with floating interest rates received on our cash equivalents and investment securities. Our swap agreements, which are considered derivative instruments, exchange the fixed interest rate under our 5.875%, 5.500%, 3.950% and 5.950% senior notes for a variable interest rate based on SOFR. Interest rate swaps with notional amounts of $650 million, maturing September 1, 2032, $300 million, maturing March 15, 2033, $450 million maturing August 15, 2049 and $400 million, maturing March 15, 2034, were outstanding on our 5.875%, 5.500%, 3.950% and 5.950% senior notes, respectively, at December 31, 2023. These swap agreements were qualified and designated as a fair value hedge. Our interest rate swaps are recognized in other assets or other liabilities, as appropriate, in our consolidated balance sheets at fair value as of the reporting date. Our interest rate swaps are highly effective at reflecting the fair value of our hedged fixed rate senior notes payable. We utilize market-based financing rates, forward yield curves and discount rates in determining fair value of these swaps at each reporting date, a Level 2 measure within the fair value hierarchy. The swap asset, included within other long-term assets on our consolidated balance sheet, was approximately $68 million at December 31, 2023. We include the gain or loss on the swap agreements in interest expense on our consolidated statement of income, the same line item as the offsetting loss or gain on the related senior notes. The gain or loss due to hedge ineffectiveness was not material for the year ended December 31, 2023.

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 $10.8 billion at December 31, 2023 and $10.0 billion at December 31, 2022. The fair value of our senior note debt was $10.6 billion at December 31, 2023 and $9.4 billion at December 31, 2022. 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 commercial paper borrowings were $0.9 billion at December 31, 2023 and the term loan and commercial paper borrowings were $1.1 billion at December 31, 2022.

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 expense (income), net in our consolidated statements of income for the year ended December 31, 2021.

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 $595 million and $18 million, respectively, at December 31, 2023. The put and call options fair values, derived from the Monte Carlo simulation, were $267 million and $10 million, respectively, at December 31, 2022.

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, 2023 and 2022, respectively:

	December 31, 2023	December 31, 2022
Annualized volatility	16.1% - 17.8%	16.7% to 20.8%
Credit spread	0.9% - 1.1%	1.3% to 1.5%
Revenue exit multiple	1.5x - 2.5x	1.5x - 2.5x
Weighted average cost of capital	11.0% - 12.5%	11.5% to 12.5%
Long term growth rate	3.0 %	3.0 %

The assumptions used for annualized volatility, credit spread and weighted average cost of capital reflect the lowest and highest values where they differ significantly across the series of put and call options due to their expected exercise dates.

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.

As disclosed in Note 3, we completed the sale of a 60% interest in Gentiva Hospice on August 11, 2022. The carrying value of the assets and liabilities of Gentiva Hospice disposed approximates fair value. The amount of

goodwill included in the carrying value is based on the relative fair value of Gentiva Hospice as compared to the total fair value of our home solutions reporting unit included within the CenterWell segment.

Additionally, as disclosed in Note 3, we completed our acquisitions of certain health and wellness related businesses during 2023, 2022, and 2021. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the related tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected cash flows and discount rates in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2023, 2022, or 2021.

7. MEDICARE PART D

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, 2023 and 2022. 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. For additional information regarding our prescription drug benefits coverage in accordance with Medicare Part D, refer to Note 2 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K.

	2023		2022	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 224	$ 514	$ 240	$ 696
Trade accounts payable and accrued expenses	(232)	(1,825)	(166)	(1,236)
Net current (liability) asset	(8)	(1,311)	74	(540)
Other long-term assets	17	—	19	—
Other long-term liabilities	(77)	—	(78)	—
Net long-term liability	(60)	—	(59)	—
Total net (liability) asset	$ (68)	$ (1,311)	$ 15	$ (540)

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2023 and 2022.

	2023	2022
	(in millions)	
Land	$ 16	$ 17
Buildings and leasehold improvements	1,002	1,143
Equipment	1,320	1,246
Computer software	3,546	3,951
	5,884	6,357
Accumulated depreciation	(2,854)	(3,136)
Property and equipment, net	$ 3,030	$ 3,221

Depreciation expense was $831 million in 2023, $749 million in 2022, and $640 million in 2021, including amortization expense for capitalized internally developed and purchased software of $589 million in 2023, $525 million in 2022, and $443 million in 2021.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2023 and 2022 were as follows:

	Insurance	CenterWell	Total
		(in millions)	
Balance at January 1, 2022	$ 2,290	$ 8,802	$ 11,092
Acquisitions	182	199	381
Dispositions	—	(2,331)	(2,331)
Balance at December 31, 2022	2,472	6,670	9,142
Acquisitions	191	217	408
Balance at December 31, 2023	$ 2,663	$ 6,887	$ 9,550

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, 2023 and 2022:

	Weighted Average Life	2023			2022		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Certificates of need	Indefinite	$ 1,092	$ —	$ 1,092	$ 1,132	$ —	$1,132
Medicare licenses	Indefinite	288	—	288	286	—	286
Customer contracts/relationships	9.4 years	956	718	238	929	673	256
Trade names and technology	6.7 years	139	109	30	142	107	35
Provider contracts	11.9 years	67	62	5	73	63	10
Noncompetes and other	8.4 years	84	44	40	86	40	46
Total other intangible assets	9.2 years	$ 2,626	$ 933	$ 1,693	$ 2,648	$ 883	$1,765

Amortization expense for other intangible assets was approximately $67 million in 2023, $81 million in 2022, and $65 million in 2021.

During 2023 we recorded impairment charges of $55 million relating to indefinite-lived intangibles.

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

	(in millions)
2024	$ 60
2025	58
2026	43
2027	33
2028	28

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 $510 million and $515 million at December 31, 2023 and December 31, 2022, respectively. Operating lease liabilities included within trade accounts payable and accrued expenses in our consolidated balance sheets were $149 million and $152 million at December 31, 2023 and December 31, 2022, respectively. Additionally, operating lease liabilities included within other long-term liabilities in our consolidated balance sheets were $444 million and $456 million at December 31, 2023 and December 31, 2022, respectively. The classification of our operating lease liabilities is based on the remaining lease term.

For the years ended December 31, 2023, 2022 and 2021, total fixed operating lease costs, excluding short-term lease costs, were $145 million, $183 million and $159 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, 2023, 2022 and 2021. In addition, for the years ended December 31, 2023, 2022 and 2021, total variable operating lease costs were $120 million, $101 million and $94 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, 2023, 2022 and 2021, sublease rental income was $66 million, $52 million and $43 million, respectively, and is included within operating costs in our consolidated statements of income.

The weighted average remaining lease term is 5.4 years at December 31, 2023 and December 31, 2022. The weighted average discount rate is 3.9% and 3.2% at December 31, 2023 and December 31, 2022, respectively. For the years ended December 31, 2023, 2022 and 2021, cash paid for amounts included in the measurement of lease liabilities included within our operating cash flows was $166 million, $191 million and $165 million, respectively.

Maturity of Lease Liabilities	**December 31, 2023**
For the years ended December 31,	**(in millions)**
2024	$ 169
2025	145
2026	102
2027	75
2028	54
After 2028	108
Total lease payments	653
Less: Interest	60
Present value of lease liabilities	$ 593

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, which represents our Insurance segment net of eliminations, activity in benefits payable was as follows for the years ended December 31, 2023, 2022 and 2021:

	2023	2022	2021
		(in millions)	
Balances at January 1	$ 9,264	$ 8,289	$ 8,143
Acquisitions	62	—	42
Incurred related to:			
Current year	89,266	76,105	70,024
Prior years	(872)	(415)	(825)
Total incurred	88,394	75,690	69,199
Paid related to:			
Current year	(79,545)	(67,287)	(62,149)
Prior years	(7,934)	(7,428)	(6,946)
Total paid	(87,479)	(74,715)	(69,095)
Balances at December 31	$ 10,241	$ 9,264	$ 8,289

The total estimate of benefits payable for claims incurred but not reported, or IBNR, is included within the net incurred claims amounts. At December 31, 2023 and 2022, benefits payable included IBNR of approximately $6.6 billion and $5.7 billion, primarily associated with claims incurred in each respective year. The cumulative number of reported claims as of December 31, 2023 was approximately 200.0 million for claims incurred in 2023, 182.4 million for claims incurred in 2022, and 173.7 million for claims incurred in 2021.

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 $872 million in 2023, $415 million in 2022, and $825 million in 2021.

The medical claims reserve development for 2023, 2022, and 2021 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. The favorable development recognized in 2023 and 2021 primarily resulted from trend factors developing more favorably than originally expected as well as for 2021 completion factors developing faster than expected. The favorable development recognized in 2022 resulted primarily from completion factors remaining largely unchanged, resulting in lower overall development as compared to 2023 and 2021.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development as of December 31, 2023, 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, 2022 and 2021 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.

The following tables provide information about incurred and paid claims development as of December 31, 2023, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2021 Unaudited**	**2022 Unaudited**	**2023**
		(in millions)	
2021 & Prior	$ 70,066	$ 69,698	$ 69,484
2022		76,105	75,447
2023			89,328
Total			$ 234,259

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	**2021 Unaudited**	**2022 Unaudited**	**2023**
		(in millions)	
2021 & Prior	$ 62,149	$ 69,252	$ 69,484
2022		67,287	74,989
2023			79,545
Total			224,018
All outstanding benefit liabilities before 2021, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 10,241

For additional information regarding our benefits payable and benefits expense recognition, refer to Note 2 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in this Form 10-K.

12. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2023, 2022 and 2021:

	2023	2022	2021
		(in millions)	
Current provision:			
Federal	$ 915	$ 755	$ 466
States and Puerto Rico	85	107	4
Total current provision	1,000	862	470
Deferred (benefit) expense	(164)	(100)	15
Provision for income taxes	$ 836	$ 762	$ 485

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2023, 2022 and 2021 due to the following:

	2023	2022	2021
		(in millions)	
Income tax provision at federal statutory rate	$ 698	$ 750	$ 718
States, net of federal benefit, and Puerto Rico	61	49	18
Tax exempt investment income	(3)	(3)	(3)
Nondeductible executive compensation	19	30	33
Non-taxable KAH gain	—	—	(264)
Tax effect from sale of Gentiva Hospice	—	(72)	—
Unrecognized Tax Benefits	37	—	—
Other, net	24	8	(17)
Provision for income taxes	$ 836	$ 762	$ 485

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, 2023 and 2022 were as follows:

	Assets (Liabilities)	
	2023	2022
	(in millions)	
Net operating loss carryforward	$ 84	$ 105
Compensation and other accrued expense	218	158
Benefits payable	150	103
Deferred acquisition costs	43	43
Jobs tax credits	—	22
Other	16	16
Unearned revenues	5	7
Investment securities	419	454
Total deferred income tax assets	935	908
Valuation allowance	(73)	(57)
Total deferred income tax assets, net of valuation allowance	862	851
Depreciable property and intangible assets	(642)	(740)
Prepaid expenses	(156)	(132)
Other	(16)	(6)
Total deferred income tax liabilities	(814)	(878)
Total net deferred income tax assets (liabilities)	$ 48	$ (27)

All deferred tax assets and liabilities are classified as noncurrent in our consolidated balance sheets as other long-term assets and liabilities at December 31, 2023 and 2022, respectively.

At December 31, 2023, we had approximately $7 million of federal net operating losses and approximately $1.2 billion of pre-apportioned 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 2024 through 2041. 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 $73 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 2021 and prior years. Our 2022 tax return is in the post-filing review period under the Compliance Assurance Process, or CAP. Our 2023 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 2020. 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, 2023 and 2022:

	2023	2022
	(in millions)	
Short-term debt:		
Commercial paper	$ 871	$ 595
Senior notes:		
$600 million, 3.850% due October 1, 2024	572	—
$1.5 billion, 0.650% due August 3, 2023	—	1,497
Total senior notes	572	1,497
Total short-term debt	$ 1,443	$ 2,092
Long-term debt:		
Senior notes:		
$600 million, 3.850% due October 1, 2024	$ —	$ 599
$600 million, 4.500% due April 1, 2025	598	597
$500 million, 5.700% due March 13, 2026	498	—
$750 million, 1.350% due February 3, 2027	688	745
$600 million, 3.950% due March 15, 2027	537	597
$500 million, 5.750% due March 1, 2028	495	494
$500 million, 5.750% due December 1, 2028	495	—
$750 million, 3.700% due March 23, 2029	590	743
$500 million, 3.125% due August 15, 2029	433	496
$500 million, 4.875% due April 1, 2030	496	495
$750 million 2.150% due February 3, 2032	743	743
$750 million, 5.875% due March 1, 2033	750	739
$850 million, 5.950% due March 15, 2034	840	—
$250 million, 8.150% due June 15, 2038	261	261
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.950% due October 1, 2044	740	740
$400 million, 4.800% due March 15, 2047	396	396
$500 million, 3.950% due August 15, 2049	529	493
$750 million, 5.500% due March 15, 2053	728	—
Total senior notes	10,213	8,534
Term loans:		
Delayed draw term loan, due May 28, 2024	—	500
Total long-term debt	$ 10,213	$ 9,034

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)
2024	$ 1,443
2025	600
2026	500
2027	1,231
2028	1,000
Thereafter	6,930

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 8.150% 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 November 2023, we issued $500 million of 5.750% unsecured senior notes due December 1, 2028 and $850 million of our 5.950% unsecured senior notes due March 15, 2034. Our net proceeds, reduced for the underwriters' discounts and commissions paid, were $1.3 billion. We used the net proceeds for general corporate purposes, which included the repayment of existing indebtedness, including borrowings under our commercial paper program.

In March 2023, we issued $500 million of 5.700% unsecured senior notes due March 13, 2026 and $750 million of 5.500% unsecured senior notes due March 15, 2053. Our net proceeds, reduced for the underwriters' discounts and commissions paid, were $1.2 billion. We used the net proceeds to repay outstanding amounts under our $500 million Delayed Draw Term Loan. The remaining net proceeds were used for general corporate purposes, which included the repayment of existing indebtedness, including borrowings under our commercial paper program.

In August 2023, we entered into a Rule 10b5-1 Repurchase Plan to repurchase a portion of our $750 million aggregate principal amount of 1.350% senior notes maturing in February 2027, our $600 million aggregate principal amount of 3.950% senior notes maturing in March 2027, our $750 million aggregate principal amount of 3.700% senior notes maturing in March 2029, and our $500 million aggregate principal amount of 3.125% senior notes maturing in August 2029 during the period beginning on August 7, 2023 and ending on November 15, 2023. For the year ended December 31, 2023, we repurchased $339 million principal amount of these senior notes for approximately $310 million cash.

In March 2023, we entered into a Rule 10b5-1 Repurchase Plan to repurchase a portion of our $1.5 billion aggregate principal amount of 0.650% senior notes maturing in August 2023 and our $600 million aggregate principal amount of 3.850% senior notes maturing in October 2024 during the period beginning on March 13, 2023 and ending on July 21, 2023. For the year ended December 31, 2023, we repurchased $361 million principal amount of these senior notes for approximately $358 million cash. We repaid the remaining $1.2 billion aggregate principal amount of our 0.650% senior notes due on their maturity date of August 3, 2023.

During 2023, we entered into interest rate swap agreements to exchange the fixed interest rate under our 5.875%, 5.500%, 3.950% and 5.950% senior notes for a variable interest rate based on SOFR, as further described in Note 6. As a result, the carrying value of these senior notes has been adjusted to reflect changes in value caused by an increase or decrease in interest rates. The cumulative, aggregate adjustment to the carrying value of the 5.875%, 5.500%, 3.950% and 5.950% senior notes was $9 million, $13 million, $36 million and $10 million respectively, at December 31, 2023.

Revolving Credit Agreements

In June 2023, we entered into an amended and restated 5-year, $2.5 billion unsecured revolving credit agreement (replacing the 5-year, $2.5 billion unsecured revolving credit agreement entered in June 2021) and entered into a 364-day $1.5 billion unsecured revolving credit agreement (replacing the 364-day $1.5 billion unsecured revolving credit agreement entered into in June 2022, which expired in accordance with its terms).

Under the 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 Term SOFR 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 Term SOFR, at our option.

The SOFR spread, currently 103.5 basis points under the 5-year revolving credit agreement and 105.5 basis points under the 364-day revolving credit agreement, varies depending on our credit ratings ranging from 92.0 to 130.0 basis points under the 5-year revolving credit agreement and from 94.0 to 135.0 basis points under the 364-day revolving credit agreement. We also pay an annual facility fee regardless of utilization. This facility fee, currently 9.0 basis points, under the 5-year revolving credit agreement and 7.0 basis points under the 364-day revolving agreement, varies depending on our credit ratings ranging from 8.0 to 20.0 basis points under the 5-year revolving credit agreement and from 6.0 to 15.0 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 41.8% as measured in accordance with the revolving credit agreements as of December 31, 2023. 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, 2023, we had no borrowings and approximately $18 million of letters of credit outstanding under the revolving credit agreements. Accordingly, as of December 31, 2023, we had $2.482 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. 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, 2023 was $3.3 billion, with $871 million outstanding at December 31, 2023 compared to $595 million outstanding at December 31, 2022. The outstanding commercial paper at December 31, 2023 had a weighted average annual interest rate of 5.68%.

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. We received a short-term cash advance of $100 million from FHLB with certain of our marketable securities as

collateral and subsequently repaid the outstanding balance in December 2023. As of December 31, 2023 and December 31, 2022, 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 $278 million in 2023, $286 million in 2022, and $259 million in 2021. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $457.81 on December 31, 2023, approximately 8% of the retirement and savings plan's assets were invested in our common stock, or approximately 1.3 million shares, representing approximately 1.1% of the shares outstanding as of December 31, 2023. At December 31, 2023, approximately 5.5 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, 2023, 2022, and 2021:

	2023	2022	2021
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 168	$ 207	$ 171
Stock options	7	9	9
Total stock-based compensation expense	175	216	180
Tax benefit recognized	(28)	(28)	(15)
Stock-based compensation expense, net of tax	$ 147	$ 188	$ 165

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

$30 million in 2023, $31 million in 2022, and $28 million in 2021. There was no capitalized stock-based compensation expense during these years.

At December 31, 2023, there were approximately 11.0 million shares reserved for stock award plans under the Humana Inc. 2011 Stock Incentive Plan, or 2011 Plan, and approximately 14.8 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, 3.3 million shares of common stock available for future grants assuming all stock options were granted or 1.4 million shares available for future grants assuming all restricted stock were granted. These reserved shares included giving effect to, under the 2019 Plan, 9.7 million shares of common stock available for future grants assuming all stock options were granted or 2.9 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 $508.23 in 2023, $430.06 in 2022, and $381.34 in 2021. Activity for our restricted stock was as follows for the year ended December 31, 2023:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2022	813	$ 429.22
Granted	437	508.23
Vested	(428)	389.26
Forfeited	(68)	441.20
Nonvested restricted stock at December 31, 2023	754	$ 488.06

Approximately 37% of the nonvested restricted stock at December 31, 2023 included performance-based conditions.

The fair value of shares vested was $236 million during 2023, $244 million during 2022, and $236 million during 2021. Total compensation expense not yet recognized related to nonvested restricted stock was $181 million at December 31, 2023. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

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

The weighted-average fair value of each option granted during 2023, 2022, and 2021 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:

	2023	2022	2021
Weighted-average fair value at grant date	$ 130.74	$ 113.35	$ 92.21
Expected option life (years)	3.0 years	3.6 years	3.7 years
Expected volatility	31.6 %	36.1 %	33.8 %
Risk-free interest rate at grant date	4.5 %	1.8 %	0.4 %
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, 2023:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2022	204	$ 381.37
Granted	63	508.80
Exercised	(22)	371.05
Forfeited	(3)	491.82
Options outstanding at December 31, 2023	242	$ 415.18
Options exercisable at December 31, 2023	112	$ 366.69

As of December 31, 2023, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $13 million, and a weighted-average remaining contractual term of 4.5 years. As of December 31, 2023, exercisable stock options had an aggregate intrinsic value of $10 million, and a weighted-average remaining contractual term of 3.6 years. The total intrinsic value of stock options exercised during 2023 was $3 million, compared with $32 million during 2022 and $18 million during 2021. Cash received from stock option exercises totaled $9 million in 2023, $51 million in 2022, and $30 million in 2021.

Total compensation expense not yet recognized related to nonvested options was $9 million at December 31, 2023. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years.

15. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2023, 2022 and 2021:

	2023	2022	2021
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 2,489	$ 2,806	$ 2,933
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	123,866	126,419	128,688
Dilutive effect of:			
Employee stock options	32	50	64
Restricted stock	543	625	644
Shares used to compute diluted earnings per common share	124,441	127,094	129,396
Basic earnings per common share	$ 20.09	$ 22.20	$ 22.79
Diluted earnings per common share	$ 20.00	$ 22.08	$ 22.67
Number of antidilutive stock options and restricted stock awards excluded from computation	207	205	216

16. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2021, 2022, and 2023, under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2021	$2.73	$351
2022	$3.06	$390
2023	$3.44	$428

In October 2023, the Board declared a cash dividend of $0.885 per share payable on January 26, 2024 to stockholders of record on December 29, 2023 for an aggregate amount of $108 million. In February 2024, the Board declared a cash dividend of $0.885 per share payable on April 26, 2024 to stockholders of record on March 29, 2024. 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 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 $1 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 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). 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. Upon final settlement of the January 2022 ASR Agreements with Mizuho and Wells Fargo on March 29, 2022 and March 30, 2022, respectively, we received an additional 0.1 million shares and 0.1 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 $410.96 and $411.66, respectively, bringing the total shares received under the January 2022 ASR Agreements to 2.4 million. In addition, upon settlement we reclassified the $150 million value of stock initially held back by Mizuho and Wells Fargo from capital in excess of par value to treasury stock.

On November 2, 2022, we entered into separate accelerated stock repurchase agreements, the November 2022 ASR Agreements, with Goldman Sachs & Co. LLC, or Goldman Sachs, and Mizuho Markets Americas LLC, or Mizuho, 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. In accordance with the November 2022 ASR Agreements, we made a payment of $1 billion ($500 million to Goldman Sachs on November 3, 2022 and $500 million to Mizuho on November 4, 2022) and received an initial delivery of 1.5 million shares of our common stock (0.760 million shares each from Goldman Sachs and Mizuho). We recorded the payments to Goldman Sachs and Mizuho as a reduction to stockholders' equity, consisting of an $850 million increase in treasury stock, which reflects the value of the initial 1.5 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 Goldman Sachs and Mizuho pending final settlement of the November 2022 ASR Agreements. Upon final settlement of the November 2022 ASR Agreements with Goldman Sachs and Mizuho on December 15, 2022 and December 16, 2022, respectively, we received an additional 0.177 million shares and 0.177 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 $534.16 and $533.87, respectively, bringing the total shares received under the November 2022 ASR Agreements to 1.8 million. In addition, upon settlement we reclassified the $150 million value of stock initially held back by Goldman Sachs and Mizuho from capital in excess of par value to treasury stock.

On February 15, 2023, the Board of Directors replaced the previous share repurchase authorization of up to $3 billion (of which approximately $1 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 as of February 15, 2026, which we refer to as the February 2023 repurchase authorization. During the year ended December 31, 2023, we repurchased 3.1 million common shares in open market transactions for $1.5 billion at an average price of $482.27 under the current share repurchase authorization. During the years ended December 31, 2022 and December 31, 2021, we did not repurchase shares in open market transactions.

Effective February 16, 2024, the Board of Directors replaced the February 2023 repurchase authorization (of which approximately $824 million remained unused) with a new share repurchase 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 15, 2027, which we refer to as the 2024 repurchase authorization.

Excluding shares acquired in connection with employee stock plans, share repurchases were as follows during the years ended December 31, 2023, 2022 and 2021:

		2023		2022		2021	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
			(in millions)				
February 2023	3,000	3.1	$1,500	—	$ —	—	$ —
February 2021	3,000	—	$ —	4.3	$2,000	—	$ —
Total repurchases		3.1	$1,500	4.3	$2,000	—	$ —

In connection with employee stock plans, we acquired 0.2 million common shares for $73 million in 2023, 0.2 million common shares for $96 million in 2022, and 0.2 million common shares for $79 million in 2021.

For additional information regarding our stockholders' equity, refer to Note 16 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" in our 2022 Form 10-K.

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 $12.2 billion and $11.3 billion as of December 31, 2023 and 2022, respectively, which exceeded aggregate minimum regulatory requirements of $9.8 billion and $8.4 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2024 is approximately $1.1 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $1.8 billion in 2023, $1.3 billion in 2022, and $1.6 billion in 2021.

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 $829 million in 2024, $518 million in 2025, $354 million in 2026, $273 million in 2027, and $209 million in 2028. 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, 2023, 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 83% of our total premiums and services revenue for the year ended December 31, 2023, 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 2024, and all of our product offerings filed with CMS for 2024 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 account for certain demographic characteristics and health status of our enrolled members. 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, collected from providers, to calculate the health status-related risk-adjusted premium

payment to MA plans, which CMS further adjusts for coding pattern differences between the health plans and the government fee-for-service (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 health status-adjusted 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.

CMS and the Office of the Inspector General of Health and Human Services, or HHS-OIG, perform audits of various companies' risk adjustment diagnosis data submissions. 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 that influence the calculation of health status-related premium payments to MA plans.

In 2012, CMS released an MA contract-level RADV methodology that would extrapolate the results of each CMS RADV audit sample to the audited MA contract's entire health status-related risk adjusted premium amount for the year under audit. In doing so, CMS recognized "that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model (FFS claims)." To correct for this difference, CMS stated that it would apply a "Fee-for-Service Adjuster (FFS Adjuster)" as "an offset to the preliminary recovery amount." This adjuster would be "calculated by CMS based on a RADV-like review of records submitted to support FFS claims data." CMS stated that this methodology would apply to audits beginning with PY 2011. Humana relied on CMS's 2012 guidance in submitting MA bids to CMS. Humana also launched a "Self-Audits" program in 2013 that applied CMS's 2012 RADV audit methodology and included an estimated FFS Adjuster. Humana completed Self-Audits for PYs 2011-2016 and reported results to CMS.

In October 2018, however, CMS issued a proposed rule announcing possible changes to the RADV audit methodology, including elimination of the FFS Adjuster. CMS proposed applying its revised methodology, including extrapolated recoveries without application of a FFS Adjuster, to RADV audits dating back to PY 2011. On January 30, 2023, CMS published a final rule related to the RADV audit methodology (Final RADV Rule). The Final RADV Rule confirmed CMS's decision to eliminate the FFS Adjuster. The Final RADV Rule states CMS's intention to extrapolate results from CMS and HHS-OIG RADV audits beginning with PY 2018, rather than PY 2011 as proposed. However, CMS's Final RADV Rule does not adopt a specific sampling, extrapolation or audit methodology. CMS instead stated its general plan to rely on "any statistically valid method . . . that is determined to be well-suited to a particular audit."

We believe that the Final RADV Rule fails to address adequately the statutory requirement of actuarial equivalence and violates the Administrative Procedure Act ("APA"). CMS failed to meet its legal obligations in the federal rulemaking process to give a reasoned justification for the rule or provide a meaningful opportunity for public comment. They also chose to apply the rule retroactively rather than prospectively, as required by law. Humana's actuarially certified bids through PY 2023 preserved Humana's position that CMS should apply an FFS Adjuster in any RADV audit that CMS intends to extrapolate. We expect CMS to apply the Final RADV Rule, including the first application of extrapolated audit results to determine audit settlements without a FFS Adjuster, to CMS and HHS-OIG RADV audits conducted for PY 2018 and subsequent years. The Final RADV Rule, including the lack of a FFS Adjuster, 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.

On September 1, 2023, Humana Inc. and Humana Benefit Plan of Texas, Inc. filed suit against the United States Department of Health and Human Services, and Xavier Becerra in his official capacity as Secretary, in the United States District Court, Northern District of Texas, Fort Worth Division seeking a determination that the Final RADV Rule violates the APA and should be set aside. We remain committed to working alongside CMS to promote the integrity of the MA program as well as affordability and cost certainty for our members. It is critical that MA plans are paid accurately and that payment model principles, including the application of a FFS Adjuster, 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 7% of our total premiums and services revenue for the year ended December 31, 2023 primarily serving members enrolled in Medicaid, and in certain circumstances members who qualify for both Medicaid and Medicare, under contracts with various states.

Our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2023, primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract comprises 32 states and approximately 6.0 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract, which was originally set to expire on December 31, 2022, was subsequently extended by the DoD and is currently scheduled to expire on December 31, 2024, unless further extended.

In December 2022, we were awarded the next generation of TRICARE Managed Care Support Contracts, or T-5, for the updated TRICARE East Region by the Defense Health Agency of the DoD.The T-5 East Region contract comprises 24 states, and Washington D.C., and covers approximately 4.6 million beneficiaries. The transition period for the T-5 contract began in January 2024 and will overlap the final year of the T2017 contract. The length of the contract is one transition year followed by eight annual option periods, which, if all options are exercised, would result in a total contract length of nine years.

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 cooperated with the Department of Justice, and we have not heard from the Department of Justice on this matter since 2020.

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.*, currently pending in United States District Court, Western District of Kentucky, Louisville 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 March 31, 2022, the Court denied the parties' Motions for Summary Judgement. We take seriously our obligations to comply with applicable CMS

requirements and actuarial standards of practice, and continue to vigorously defend against these allegations. During 2023, we have accrued certain anticipated expenses in connection with this matter.

On September 1, 2023, Humana Inc. and Humana Benefit Plan of Texas, Inc. filed suit against the United States Department of Health and Human Services, and Xavier Becerra in his official capacity as Secretary, in the United States District Court, Northern District of Texas, Fort Worth Division seeking a determination that the Final RADV Rule violates the APA and should be set aside. There is no assurance that we will prevail in the lawsuit. See "Government Contracts" in this Note 17 for additional information regarding this matter.

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

During December 2022, we realigned our businesses into two distinct segments: Insurance and CenterWell. The Insurance segment includes the businesses that were previously included in the Retail and Group and Specialty segments, as well as the Pharmacy Benefit Manager, or PBM, business which was previously included in the Healthcare Services segment. The CenterWell segment (formerly Healthcare Services) represents our payor-agnostic healthcare services offerings, including pharmacy solutions, primary care, and home solutions. In addition to the new segment classifications being utilized to assess performance and allocate resources, we believe this simpler structure will create greater collaboration across the Insurance and CenterWell businesses and will accelerate work that is underway to centralize and integrate operations within the organization. 2021 segment financial information was recast to conform to the 2022 presentation.

Our two reportable segments, Insurance and CenterWell, 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 Insurance segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts, as well as 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. This segment also includes products consisting 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. In addition, our Insurance segment includes our military services business, primarily our T-2017 East Region contract, as well as the operations of our PBM business.

The CenterWell segment includes our pharmacy solutions, primary care, and home solutions operations. The segment also includes our strategic partnerships with WCAS to develop and operate senior-focused, payor-agnostic, primary care centers, as well as our minority ownership interest in Gentiva Hospice operations. 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 CenterWell intersegment revenues primarily relate to the operations of CenterWell Pharmacy (our mail-order pharmacy business), CenterWell Specialty Pharmacy, and retail pharmacies jointly located within CenterWell Senior Primary Care clinics.

In addition, our CenterWell intersegment revenues includes revenues earned by certain owned providers (CenterWell Senior Primary Care) derived from certain value-based arrangements with our health plans. Under these value-based arrangements, our owned providers enter into agreements with our health plans to stand ready to deliver, integrate, direct and control the administration and management of certain health care services for our members. In exchange, the owned provider receives a premium that is typically paid on a per-member per-month basis. These value-based arrangements represent a single performance obligation where revenues are recognized in the period in which we are obligated to provide integrated health care services to our members. Fee-for-service revenue is recognized at agreed upon rates, net of contractual allowances, as the performance obligation is completed on the date of service.

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 $20.7 billion in 2023, $19.7 billion in 2022, and $18.1 billion in 2021. In addition, depreciation and amortization expense associated with certain businesses delivering benefits to our members, primarily associated with our primary care and pharmacy operations, are included with benefits expense. The amount of this expense was $138 million in 2023, $122 million in 2022, and $108 million in 2021.

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 CenterWell segment, primarily pharmacy solutions, primary care, and home solutions, to our Insurance 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 84% for 2023, 82% for 2022 and 83% for 2021.

	Insurance	CenterWell	Eliminations/ Corporate	Consolidated
		(in millions)		
2023				
External revenues				
Premiums:				
Individual Medicare Advantage	$ 78,837	$ —	$ —	$ 78,837
Group Medicare Advantage	6,869	—	—	6,869
Medicare stand-alone PDP	2,189	—	—	2,189
Total Medicare	87,895	—	—	87,895
Commercial fully-insured	3,527	—	—	3,527
Specialty benefits	1,007	—	—	1,007
Medicare Supplement	735	—	—	735
State-based contracts and other	8,108	—	—	8,108
Total premiums	101,272	—	—	101,272
Services revenue:				
Home solutions	—	1,342	—	1,342
Primary care	—	842	—	842
Commercial ASO	237	—	—	237
Military services and other	763	—	—	763
Pharmacy solutions	—	849	—	849
Total services revenue	1,000	3,033	—	4,033
Total external revenues	102,272	3,033	—	105,305
Intersegment revenues				
Services	31	4,921	(4,952)	—
Products	—	10,451	(10,451)	—
Intersegment revenues	31	15,372	(15,403)	—
Investment income	551	—	518	1,069
Total revenues	102,854	18,405	(14,885)	106,374
Operating expenses:				
Benefits	89,100	—	(706)	88,394
Operating costs	10,408	16,791	(14,011)	13,188
Depreciation and amortization	692	210	(123)	779
Total operating expenses	100,200	17,001	(14,840)	102,361
Income (loss) from operations	2,654	1,404	(45)	4,013
Interest expense	—	3	490	493
Other expense, net	—	—	137	137
Income (loss) before income taxes and equity in net losses	2,654	1,401	(672)	3,383
Equity in net losses	(6)	(57)	—	(63)
Segment earnings (loss)	$ 2,648	$ 1,344	$ (672)	$ 3,320
Net loss (income) attributable to noncontrolling interests	6	(1)	—	5
Segment earnings (loss) attributable to Humana	$ 2,654	$ 1,343	$ (672)	$ 3,325

	Insurance	CenterWell	Eliminations/ Corporate	Consolidated
		(in millions)		
2022				
External revenues				
Premiums:				
Individual Medicare Advantage	$ 65,591	$ —	$ —	$ 65,591
Group Medicare Advantage	7,297	—	—	7,297
Medicare stand-alone PDP	2,269	—	—	2,269
Total Medicare	75,157	—	—	75,157
Commercial fully-insured	4,389	—	—	4,389
Specialty benefits	1,047	—	—	1,047
Medicare Supplement	743	—	—	743
State-based contracts and other	6,376	—	—	6,376
Total premiums	87,712	—	—	87,712
Services revenue:				
Home solutions	—	2,333	—	2,333
Primary care	—	568	—	568
Commercial ASO	300	—	—	300
Military services and other	550	—	—	550
Pharmacy solutions	—	1,025	—	1,025
Total services revenue	850	3,926	—	4,776
Total external revenues	88,562	3,926	—	92,488
Intersegment revenues				
Services	56	3,532	(3,588)	—
Products	—	9,841	(9,841)	—
Intersegment revenues	56	13,373	(13,429)	—
Investment income	223	8	151	382
Total revenues	88,841	17,307	(13,278)	92,870
Operating expenses:				
Benefits	75,934	—	(244)	75,690
Operating costs	9,251	15,835	(12,415)	12,671
Depreciation and amortization	634	181	(106)	709
Total operating expenses	85,819	16,016	(12,765)	89,070
Income (loss) from operations	3,022	1,291	(513)	3,800
Gain on sale of Gentiva Hospice	—	(237)	—	(237)
Interest expense	—	—	401	401
Other expense, net	—	—	68	68
Income (loss) before income taxes and equity in net earnings (losses)	3,022	1,528	(982)	3,568
Equity in net earnings (losses)	18	(22)	—	(4)
Segment earnings (loss)	$ 3,040	$ 1,506	$ (982)	$ 3,564
Net loss (income) attributable to noncontrolling interests	5	(1)	—	4
Segment earnings (loss) attributable to Humana	$ 3,045	$ 1,505	$ (982)	$ 3,568

	Insurance	CenterWell	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
Commercial fully-insured	4,950	—	—	4,950
Specialty benefits	1,052	—	—	1,052
Medicare Supplement	731	—	—	731
State-based contracts and other	5,109	—	—	5,109
Total premiums	79,822	—	—	79,822
Services revenue:				
Home solutions	—	1,166	—	1,166
Primary care	—	413	—	413
Commercial ASO	306	—	—	306
Military services and other	547	—	—	547
Pharmacy solutions	—	623	—	623
Total services revenue	853	2,202	—	3,055
Total external revenues	80,675	2,202	—	82,877
Intersegment revenues				
Services	41	2,828	(2,869)	—
Products	—	9,024	(9,024)	—
Intersegment revenues	41	11,852	(11,893)	—
Investment income (loss)	214	4	(31)	187
Total revenues	80,930	14,058	(11,924)	83,064
Operating expenses:				
Benefits	69,639	—	(440)	69,199
Operating costs	8,340	12,968	(11,187)	10,121
Depreciation and amortization	539	152	(95)	596
Total operating expenses	78,518	13,120	(11,722)	79,916
Income (loss) from operations	2,412	938	(202)	3,148
Interest expense	—	—	326	326
Other income, net	—	—	(532)	(532)
Income before income taxes and equity in net earnings	2,412	938	4	3,354
Equity in net earnings	—	65	—	65
Segment earnings	$ 2,412	$ 1,003	$ 4	$ 3,419
Net income attributable to noncontrolling interest	—	(1)	—	(1)
Segment earnings attributable to Humana	$ 2,412	$ 1,002	$ 4	$ 3,418

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 long-term assets, were $173 million at December 31, 2023 and $181 million at December 31, 2022. The amount of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately $173 million at December 31, 2023 and approximately $181 million at December 31, 2022. Premiums ceded were $1 million in 2023, $5 million in 2022 and $6 million in 2021. Benefits ceded were $3 million in 2023, $2 million in 2022, and $2 million in 2021.

We evaluate the financial condition of our reinsurers on a regular basis. Protective Life Insurance Company with $159 million in reinsurance recoverables is well-known and well-established with a AM Best rating of A+ at December 31, 2023. The remaining reinsurance recoverables of $15 million are divided between 8 other reinsurers, with $0.4 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, 2023 and 2022, 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, 2023, including the related notes and financial statement schedule 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, 2023, 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, 2023 and 2022, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2023 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, 2023, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

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

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

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

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in

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

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

Critical Audit Matters

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

Valuation of Incurred but not yet Reported Benefits Payable

As described in Notes 2 and 11 to the consolidated financial statements, the Company's incurred but not yet reported benefits payable (IBNR) was $6.6 billion as of December 31, 2023. 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 – Home Solutions and Primary Care Reporting Units

As described in Notes 2 and 9 to the consolidated financial statements, the Company's consolidated goodwill balance was $9.6 billion as of December 31, 2023, and the goodwill associated with the Home Solutions and Primary Care Reporting Units was $4.4 billion and $1.2 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 Home Solutions and Primary Care 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 Home Solutions and Primary Care 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.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 15, 2024

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, 2023, we as the principal executive officer, the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

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

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

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2023. 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, 2023, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2023 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on pages 121-123.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2023 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

(a) None.

(b) During the three months ended December 31, 2023, no director or officer of the Company adopted or terminated a "Rule 10b5-1 trading arrangement" or "non-Rule 10b5-1 trading arrangement," as each term is defined in Item 408(a) of Regulation S-K.

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 18, 2024 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, "Business" 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 18, 2024.

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 18, 2024 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 18, 2024 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 18, 2024.

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, 2023 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)	242,006	$ 415.178	$ 13,036,391	(2)(3)(4)
Equity compensation plans not approved by security holders	—	—	—	
Total	242,006	$ 415.178	$ 13,036,391	

(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, 4,348,987 (1,445,965 from the 2011 Plan and 2,903,023 from the Amended and Restated Plan) can be issued as restricted stock at December 31, 2023 (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 18, 2024, 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 18, 2024 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 18, 2024 appearing under the caption “Audit Committee Report” of such Definitive Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULE

(a) The financial statements, Report of Independent Registered Public Accounting Firm (PCAOB ID 238), financial statement schedule 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 Schedule is included herein:

Schedule I	Parent Company Condensed Financial Information at December 31, 2023 and 2022 and for the years ended December 31, 2023, 2022 and 2021

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, effective as of December 7, 2023 (incorporated herein by reference to Exhibit 3(b) to Humana Inc.'s Current Report on Form 8-K filed on December 7, 2023).

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) 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).

(f) 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).

(g) 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).

(h) 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).

(i) 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).

(j) 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).

(k) 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).

(l) 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).

(m) 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 4.4 to Humana Inc.'s Current Report on Form 8-K, filed March 27, 2020).

(n) 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).

(o) 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).

(p) Twenty-First Supplemental Indenture, dated March 23, 2022, 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 March 23, 2022).

(q) Twenty-Second Supplemental Indenture, dated November 22, 2022, 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 November 22, 2022).

(r) Twenty-Third Supplemental Indenture, dated November 22, 2022, 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 November 22, 2022).

(s) Twenty-Fourth Supplemental Indenture, dated March 13, 2023, 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 March 13, 2023).

(t) Twenty-Fifth Supplemental Indenture, dated March 13, 2023, 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 March 13, 2023).

(u) Twenty-Sixth Supplemental Indenture, dated November 9, 2023, 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 November 9, 2023).

(v) Twenty-Seventh Supplemental Indenture, dated November 9, 2023, 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 November 9, 2023).

(w) 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)* 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).

(b)* 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).

(c)* 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).

(d)* Humana Inc. Executive Severance Policy, effective as of March 1, 2023 (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2023).

(e)* 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).

(f)* 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).

(g)* 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).

(h)* 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).

(i)* 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).

(j)* 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).

(k) Five-Year $2.5 Billion Amended and Restated Credit Agreement, dated as of June 2, 2023, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent, Bank of America, N.A. as Syndication Agent, Citibank, N.A., Goldman Sachs Bank USA, PNC Capital Markets LLC, U.S. Bank, National Association and Wells Fargo Securities, LLC, as Documentation Agents, and JPMorgan Chase Bank, N.A., BofA Securities, Inc., Citibank, N.A., Goldman Sachs Bank USA, 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 10.1 to Humana Inc.'s Current Report on Form 8-K filed on June 2, 2023)).

(l) 364-Day $1.5 Billion Revolving Credit Agreement, dated as of June 2, 2023, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent, Bank of America, N.A. as Syndication Agent, Citibank, N.A., Goldman Sachs Bank USA, PNC Capital Markets LLC, U.S. Bank, National Association and Wells Fargo Securities, LLC, as Documentation Agents, and JPMorgan Chase Bank, N.A., BofA Securities, Inc., Citibank, N.A., Goldman Sachs Bank USA, 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 10.2 to Humana Inc.'s Current Report on Form 8-K filed on June 2, 2023).

(m) Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(n) Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(o) Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(p) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(q) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(r) Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(s) Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005, File No. 001-05975).

(t)* Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).

(u)* Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).

(v)* Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).

(w)* Amendment No. 2, dated as of August 16, 2018, to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated as of February 27, 2014 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.s Current Report on Form 8-K, filed on August 20, 2018).

(x)* Humana Inc. Change in Control Policy, effective March 1, 2019 (incorporated herein by reference to Exhibit 10(aa) to Humana Inc.'s Annual Report on Form 10-K filed on February 21, 2019).

(y) Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 7, 2014).

(z)* Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(aa)* Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(bb)* Form of Company's 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).

(cc)* 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).

(dd)*	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).
(ee)*†	First Amendment to the Amended and Restated Humana Inc. Stock Incentive Plan.
(ff)*	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).
(gg)*	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).
(hh)*	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).
(ii)*	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).
(jj)*	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).
(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(qq) to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2020).
(ll)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(rr) to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2020).
(mm)*†	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan.
(nn)*†	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan.
(oo)*†	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan.
(pp)*†	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the Amended and Restated Humana Inc. Stock Incentive Plan (Non-Qualified Stock Options).
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.
97*†	Humana Inc. Compensation Recoupment Policy, effective October 2, 2023
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, 2023 and 2022; (ii) the Consolidated Statements of Income for the years ended December 31, 2023, 2022 and 2021; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2023, 2022 and 2021; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2023, 2022, and 2021; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2023, 2022 and 2021; 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(j), and Exhibits 10(t) through and including 10(x), as well as Exhibits 10(z) through and including Exhibit 10(pp) are compensatory plans or management contracts.

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

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2023	2022
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 250	$ 614
Investment securities	260	320
Receivable from operating subsidiaries	2,050	1,807
Other current assets	717	577
Total current assets	3,277	3,318
Property and equipment, net	2,334	2,393
Investment in subsidiaries	29,666	27,905
Other long-term assets	348	282
Total assets	$ 35,625	$ 33,898
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 5,768	$ 5,421
Short-term debt	1,443	2,092
Current portion of notes payable to operating subsidiaries	36	36
Book overdraft	75	73
Other current liabilities	1,566	1,425
Total current liabilities	8,888	9,047
Long-term debt	10,213	9,034
Other long-term liabilities	262	506
Total liabilities	19,363	18,587
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; 198,690,082 shares issued at December 31, 2023 and 198,666,598 shares issued at December 31, 2022	33	33
Capital in excess of par value	3,346	3,246
Retained earnings	27,540	25,492
Accumulated other comprehensive (loss) income	(999)	(1,304)
Treasury stock, at cost, 76,465,862 shares at December 31, 2023 and 73,691,955 shares at December 31, 2022	(13,658)	(12,156)
Total stockholders' equity	16,262	15,311
Total liabilities and stockholders' equity	$ 35,625	$ 33,898

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,		
	2023	2022	2021
		(in millions)	
Revenues:			
Management fees charged to operating subsidiaries	$ 2,075	$ 1,554	$ 1,633
Investment and other (loss) income, net	42	(88)	(266)
Total revenues	2,117	1,466	1,367
Expenses:			
Operating costs	2,016	1,700	1,404
Depreciation	656	581	488
Interest	489	400	313
Total expenses	3,161	2,681	2,205
Other income, net	(184)	—	(672)
Loss before income taxes and equity in net earnings of subsidiaries	(860)	(1,215)	(166)
Benefit for income taxes	(146)	(266)	(259)
(Loss) income before equity in net earnings of subsidiaries	(714)	(949)	93
Equity in net earnings of subsidiaries	3,203	3,755	2,761
Equity in net earnings of equity method investments	—	—	79
Net income attributable to Humana	$ 2,489	$ 2,806	$ 2,933

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,		
	2023	2022	2021
		(in millions)	
Net income attributable to Humana	$ 2,489	$ 2,806	$ 2,933
Other comprehensive income (loss):			
Change in gross unrealized investment gains (losses)	372	(1,819)	(356)
Effect of income taxes	(85)	418	81
Total change in unrealized investment gains (losses), net of tax	287	(1,401)	(275)
Reclassification adjustment for net realized losses (gains) included in investment income	25	72	(103)
Effect of income taxes	(7)	(17)	23
Total reclassification adjustment, net of tax	18	55	(80)
Other comprehensive income (loss), net of tax	305	(1,346)	(355)
Comprehensive income attributable to equity method investments	—	—	6
Comprehensive income attributable to Humana	$ 2,794	$ 1,460	$ 2,584

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,		
	2023	2022	2021
	(in millions)		
Net cash provided by operating activities	$ 3,042	$ 4,868	$ 2,853
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(233)	(337)	(4,187)
Capital contributions to operating subsidiaries	(792)	(484)	(2,580)
Purchases of property and equipment, net	(761)	(931)	(958)
Purchases of investment securities	(17)	(63)	(200)
Proceeds from sale of investment securities	41	468	71
Maturities of investment securities	67	30	122
Net cash used in investing activities	(1,695)	(1,317)	(7,732)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	2,537	1,976	2,953
Repayments of senior notes	(1,832)	(1,000)	—
Proceeds (repayments) from issuance of commercial paper, net	211	(376)	352
Proceeds from issuance of term loan	—	—	2,500
Repayment of term loan	(500)	(2,000)	—
Change in book overdraft	2	5	(52)
Common stock repurchases	(1,573)	(2,096)	(79)
Dividends paid	(431)	(392)	(354)
Proceeds from stock option exercises and other	(125)	40	29
Net cash (used in) provided by financing activities	(1,711)	(3,843)	5,349
(Decrease) increase in cash and cash equivalents	(364)	(292)	470
Cash and cash equivalents at beginning of year	614	906	436
Cash and cash equivalents at end of year	$ 250	$ 614	$ 906

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

Services Fee

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

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $1.8 billion in 2023, $1.3 billion in 2022, and $1.6 billion in 2021.

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 $12.2 billion and $11.3 billion as of December 31, 2023 and 2022, respectively, which exceeded aggregate minimum regulatory requirements of $9.8 billion and $8.4 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2024 is approximately $1.1 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $1.8 billion in 2023, $1.3 billion in 2022, and $1.6 billion in 2021.

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 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K for a description of certain acquisitions.

5. INCOME TAXES

Refer to Note 12 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 13 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K for a description of debt.

7. STOCKHOLDERS' EQUITY

Refer to Note 16 to the audited Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Form 10-K for a description of stockholders’ equity, including stock repurchases and stockholder dividends.

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 15, 2024

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 15, 2024
/s/ JOHN-PAUL W. FELTER **John-Paul W. Felter**	Senior Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)	February 15, 2024
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	Chief Executive Officer, Director (Principal Executive Officer)	February 15, 2024
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 15, 2024
/s/ RAQUEL C. BONO, M.D. **Raquel C. Bono, M.D.**	Director	February 15, 2024
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 15, 2024
/s/ DAVID T. FEINBERG, M.D. **David T. Feinberg, M.D.**	Director	February 15, 2024
/s/ WAYNE A. I. FREDERICK, M.D. **Wayne A. I. Frederick, M.D.**	Director	February 15, 2024
/s/ JOHN W. GARRATT **John W. Garratt**	Director	February 15, 2024
/s/ KAREN W. KATZ **Karen W. Katz**	Director	February 15, 2024
/s/ MARCY S. KLEVORN **Marcy S. Klevorn**	Director	February 15, 2024
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 15, 2024
/s/ JORGE S. MESQUITA **Jorge S. Mesquita**	Director	February 15, 2024
/s/ BRAD D. SMITH **Brad D. Smith**	Director	February 15, 2024

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Sources

1. Centers for Medicare & Medicaid Services, Monthly Contract and Enrollment Summary Report, December 2023.
2. Kaiser Family Foundation, A Snapshot of Sources of Coverage Among Medicare Beneficiaries, December 2023.
3. Better Medicare Alliance, Medicare Advantage Offers $2,400 in Annual Cost Savings for Seniors, March 6, 2023. Available at: https://bettermedicarealliance.org/news/medicare-advantage-offers-2400-in-annual-cost-savings-for-seniors/.
4. Kaiser Family Foundation, Medicare Advantage in 2022: Enrollment Update and Key Trends, August 25, 2022.
5. CMS enrollment files as of January 2024; Parts A and B eligible lives only.
6. U.S. Census Bureau, Projected Age Groups and Sex Composition of the Population: Main Projections Series for the United States, 2017-2060. Available at: https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html.

Corporate headquarters

The Humana Building | 500 West Main Street | Louisville, KY 40202 | **502-580-1000** | **Humana.com**

More information about Humana Inc.

Copies of the Company's filings with the U.S. Securities and Exchange Commission may be obtained without charge via the Investor Relations page of the Company's internet site at **Humana.com** or by writing:

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Humana®

A more human way to healthcare®