AETNA INC /PA/
Form 10-K
February 17, 2017

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K
(Mark One)
þ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2016
or
o 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 1-16095
Aetna Inc.
(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	23-2229683 (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	06156 (Zip Code)
Registrant's telephone number, including area code	(860) 273-0123

Securities registered pursuant to Section 12(b) of the Act: Title of each class Common Shares, $.01 par value	Name of each exchange on which registered 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.	þ Yes o 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.	o Yes þ 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	þ Yes o No

filing requirements for the past 90 days.

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).	þYes o No
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.	o

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

Large accelerated filer	þ	Accelerated filer	o
Non-accelerated filer	o	(Do not check if smaller reporting company) Smaller reporting company	o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act)	oYes þNo

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2016) was $41.8 billion.

There were 351.7 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2017.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement related to Aetna Inc.'s 2017 Annual Meeting of Shareholders, to be filed on or about April 7, 2017 (the “Proxy Statement”), is incorporated by reference in Parts III and IV to the extent described therein.

Aetna Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2016

Table of Contents

FORWARD-LOOKING INFORMATION

The Private Securities Litigation Reform Act of 1995 (the "1995 Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We want to take advantage of these safe harbor provisions.

Certain information contained in this Annual Report on Form 10-K is forward-looking within the meaning of the 1995 Act or SEC rules. This information includes, but is not limited to: "Outlook for 2017" and "Regulatory Environment" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Part II, Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Part II, Item 7A, and "Risk Factors" included in Part I, Item 1A. In addition, throughout this Annual Report on Form 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions, when we intend to identify forward-looking statements:

·Expects	·Intends	·Seeks	·Will	·Potential
·Projects	·Plans	·Estimates	·Should	·Continue
·Anticipates	·Believes	·May	·Could	·View
·Outlook	·Guidance	·Predict	·Likely	·Probable
·Forecast	·Can	·Explore	·Evaluate	·Might

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these uncertainties and other factors are outside our control. Certain of these uncertainties and other factors are described under "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K. You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this report, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

Unless the context otherwise requires, references to the terms "we", "our" or "us" used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) ("Aetna") and its subsidiaries (collectively, the "Company").

Part I

Item 1. Business

General

We are one of the nation's leading diversified health care benefits companies, serving an estimated 46.7 million people. We have the information and resources to help our members, in consultation with their health care professionals, make better informed decisions about their health care. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, medical management capabilities, Medicaid health care management services, Medicare Advantage and Medicare Supplement plans, workers' compensation administrative services and health information technology ("HIT") products and services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

2016 Accomplishments

We are working to build healthier communities, a healthier nation and a healthier world. Our operational, financial and strategically important accomplishments during 2016 included:

- Continued strong performance in our Government businesses including;

Expanding our presence in Government programs through membership growth in Medicare Advantage, Medicare Supplement and Medicaid as well as through programs for members who are dually eligible for both Medicare and Medicaid ("Duals").

Increasing our percentage of Medicare Advantage members in plans with 2017 star ratings of at least 4.0 stars for the third consecutive year to 92 percent, based on our membership as of December 31, 2016, the highest percentage among our publicly traded peers.

- Delivering solid results in our Commercial ASC and fee-based businesses driven by positive fee yields and a focus on cost control.

- Successfully advancing our strategy to help transform the healthcare system from volume-based payment models to ones that reward the quality and value provided. We formed multiple collaborations with healthcare providers that span a wide spectrum of value-based care models, including two new joint venture relationships. We carried that momentum into 2017 with the announced signing of a new joint venture with Allina Health in Minneapolis. We made solid progress in 2016, with over 45 percent of Aetna's medical spend currently flowing through some form of value-based care model, positioning us to achieve our 2020 goal of 75 percent.

- Participating in a number of private health insurance exchanges ("Private Exchanges") in 2016. We continue to believe that Private Exchanges are an efficient way for plan sponsors to shift towards a defined contribution model for employee health benefits, and we expect to continue our participation in 2017.

- Making progress in developing a portfolio of products and tools that will help to transform the health benefits industry to a retail model that is consumer-centric, affordable and convenient. In 2016, we signed an agreement with Apple that we believe will improve our members' health experience by combining the power of iOS apps and the renowned user experience of Apple products, including Apple Watch, iPhone and iPad, with Aetna's analytics-based wellness and care management programs.

Terminated Acquisition of Humana Inc. ("Humana") and Terminated Divestiture to Molina

On July 2, 2015, we entered into a definitive agreement (the "Merger Agreement") to acquire Humana (the "Humana Acquisition") in a transaction valued at approximately $37 billion, based on the closing price of Aetna common shares on July 2, 2015, including the assumption of Humana debt and Humana cash and cash equivalents.

On July 21, 2016, the U.S. Department of Justice (the "DOJ") and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that the Humana Acquisition would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Acquisition. On February 14, 2017, Aetna and Humana entered into a mutual termination agreement (the "Termination Agreement") pursuant to which the parties thereto (collectively the "Parties") agreed to terminate the Merger Agreement, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby, entered pursuant thereto or entered in connection therewith (other than certain confidentiality agreements) (collectively with the Merger Agreement, the "Transaction Documents"), effective immediately as of February 14, 2017 (the "Termination Date"). Under the Termination Agreement, Aetna agreed to

pay Humana the Regulatory Termination Fee (as defined in the Merger Agreement) of $1.0 billion in cash in full satisfaction of any amounts required to be paid by Aetna under the Merger Agreement. The Parties also agreed to release each other from any and all liability, claims, rights, actions, causes of action, suits, liens, obligations, accounts, debts, demands, agreements, promises, liabilities, controversies, costs, charges, damages, expenses and fees, however arising, in connection with, arising out of or related to the Transaction Documents, the transactions contemplated therein or thereby or certain related matters. We paid Humana the Regulatory Termination Fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes (as defined below).

In June 2016, we issued $13.0 billion of senior notes to partially fund the Humana Acquisition (collectively, the "2016 senior notes"). In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for $10.2 billion aggregate principal amount of certain of the 2016 senior notes (collectively, the "Special Mandatory Redemption Notes") at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017, and we expect to fund the redemption with the proceeds of the 2016 senior notes. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption.

In order to address the DOJ's perceived competitive concerns regarding Medicare Advantage relating to the Humana Acquisition, on August 2, 2016, we entered into a definitive agreement (the "Aetna APA") to sell for cash to Molina Healthcare, Inc. ("Molina") certain of our Medicare Advantage assets. On February 14, 2017, Aetna and Molina entered into a Termination Agreement (the "APA Termination Agreement") pursuant to which Aetna terminated the Molina APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, Aetna agreed to pay Molina in cash (a) a termination fee of $53 million and (b) approximately 70% of Molina's transaction costs. We paid Molina the termination fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes. We expect to pay Molina the applicable transaction costs during the first quarter of 2017.

Heath Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate efforts in 2017 and beyond to substantially modify, repeal or replace the ACA, we expect aspects of the ACA to continue to significantly impact our business operations and operating results, including our pricing, our medical benefit ratios ("MBRs") and the geographies in which our products are available. The ACA has presented us with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including public health insurance exchanges ("Public Exchanges" and together with Private Exchanges, "Insurance Exchanges"), required minimum Medical Loss Ratios ("MLRs") in Commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's Centers for Medicare & Medicaid Services ("CMS") quality performance ratings or "star ratings." The effects of these changes are reflected in our operating results. If the ACA is not amended, repealed or replaced certain of its components will continue to be phased in until 2020. For additional information on federal and state health care reform, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K and for a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with health care reform, see "Risk Factors" included in Part I, Item 1A of this Annual

Report on Form 10-K.

Reportable Segments

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. We derive our revenues primarily from insurance premiums, administrative service fees, net investment income and other revenue. Refer to MD&A included in Part II, Item 7 and Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K regarding revenue and profit information for each of our business segments and revenue and asset information about geographic areas. The following is a description of each of our business segments.

Health Care Segment

Products and Services

We refer to insurance products (where we assume all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care products and services consist of the following:

- Commercial Medical: We offer point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Our Commercial medical products also include health savings accounts ("HSAs") and Aetna HealthFund® consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Our principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates.
- Government Medical: In select geographies, we offer Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participate in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participate in Duals demonstration projects. These Government products are further described below:
  - Medicare: Through annual contracts with CMS, we offer HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over Original Medicare fee-for-service coverage, including reduced cost-sharing for preventive care, vision and other services. We offered network-based HMO and/or PPO plans in 1,093 counties in 39 states and Washington, D.C. in 2016. We are expanding to 1,213 counties in 40 states and Washington, D.C. in 2017. We are a national provider of the Medicare Part D Prescription Drug Program ("PDP") in all 50 states and Washington, D.C. to both individuals and employer groups. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. For certain qualifying employer groups, we offer our Medicare PPO products nationally. When combined with our PDP product, these national PPO plans form an integrated national fully-insured Medicare product for employers that provides medical and pharmacy benefits.
  - Medicare Supplement: For certain Medicare eligible members, we offer supplemental coverage for certain health care costs not covered by Original Medicare. The products included in our Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. We offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2016.
  - Medicaid and CHIP: We offer health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. We offered these services on an Insured or ASC basis in 16 states in 2016.
  - Duals: We provide health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. We coordinate 100% of the care for these members and may provide them with additional services in order to manage their health care costs. During 2016, we offered services on an Insured basis to members who were dually eligible in four states under demonstration projects.
- Dental: We offer managed dental plans on an Insured and ASC basis. We are one of the nation's largest providers of dental coverage, based on membership at December 31, 2016.
- Behavioral Health: Our behavioral health and employee assistance products provide members who experience stress, depression and other types of mental health related illness with integrated behavioral health benefit administration, access to a network of providers and innovative wellness programs. We provide customized behavioral health solutions to members in all 50 states.
- Provider Network Access ("First Health" and "Cofinity"): Through our First Health and Cofinity products, we provide access to health care provider networks to other insurance companies, third-party administrators, health plans and employers. First Health products are marketed nationally, while Cofinity products are marketed in certain states.

- Stop Loss: We offer medical stop loss insurance coverage for certain employers who elect to self insure their health benefits. Under this product, we assume risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.

- Aetna Vision℠ Preferred: We offer vision benefits that provide members with access to one of the largest vision networks in the U.S. The Aetna Vision Preferred program can be customized with a wide range of benefit levels and co-payments.
- Workers' Compensation Administrative Services: Our workers' compensation administrative services products and services consist of fee-based, managed care services, such as provider network access, cost containment services, pharmacy benefit management, durable medical equipment and ancillary services, and care management services to underwriters and administrators of workers' compensation insurance.
- Consumer Health and Services: We have a portfolio of products aimed at creating an holistic and integrated approach to individual health and wellness, including products previously marketed under the Healthagen® brand. These products and services complement our Commercial, Medicare and Medicaid products.
- Pharmacy: We offer pharmacy benefit management services and specialty and mail order pharmacy services to our members. Our pharmacy fulfillment services are delivered by Aetna Specialty Pharmacy ("ASP") and Aetna Rx Home Delivery®. ASP dispenses specialty medications and offers certain support services associated with specialty medications. Specialty medications include injectable or infused medications that may not be readily available at local pharmacies. Aetna Rx Home Delivery® provides mail order prescription drug services. CaremarkPCS Health, L.L.C. performs the administration of selected functions for our retail pharmacy network contracting and claims administration; mail order and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services for us. Another supplier also provides certain pharmacy benefit management services to us and our customers.
- Advanced Provider Models ("APM"): We are focused on growing membership in our medical products through provider collaborations that are designed to lower medical costs for us and our customers and make our products more affordable. These collaboration models include joint ventures and accountable care organizations ("ACOs"). We offer a suite of solutions designed to facilitate delivery system reform and help reduce the cost of care by enabling population health management for providers. Our APM products facilitate providers changing their business model from episodic acute care to patient population management which allows them to convert from volume-based reimbursement to value-based reimbursement. Our APM products deploy Aetna's population health management assets to collaborate with providers in new ways to improve the quality and efficiency of care for all patients, whether they are Aetna members or members of other payors. In 2016, we continued expanding our offering of APM products and services to employers and individuals in more geographic areas to create mutually beneficial relationships with providers through a variety of methods, including alignment of financial incentives based on cost and quality, implementation of innovative HIT and deploying leading care management programs. Our APM relationships include joint ventures with Allina Health, Banner Health Network, Inova Health System and Texas Health Resources.
- ActiveHealth Management: Through the use of our patented CareEngine® system, our ActiveHealth Management products provide evidence-based medical management and data analytics products and services to a broad range of customers, including health plans, employers and others. ActiveHealth Management also is a key component of our APM solutions.
- Medicity: Medicity is a health information exchange company and a key component of our APM and provider enablement solutions. Medicity offers a set of convenient, easy-to-access technology solutions for physicians, hospitals and other health care providers. These capabilities allow us to further the adoption of electronic health records and contribute to initiatives that foster administrative simplicity in health care, a key issue for consumers, patients and providers. Medicity provides customers clinical data integration and secure data exchange capabilities.
- Consumer: We believe the role of the consumer in health care is changing and that consumers will become the primary decision makers when it comes to choosing their health-related benefits. As a result, we are developing a portfolio of products and tools, including bswift and iTriage, that are designed for a retail model in the health benefits industry that is consumer-centric, affordable and convenient. Our Consumer business is focusing on developing a simplified, integrated offering to help consumers navigate the health care system and manage their health care costs. bswift: bswift provides benefit administration technology and services to employers nationwide, streamlining the benefits process. bswift's technology also provides the shopping, buying and enrolling experience for Public Exchanges, Private Exchanges and individuals.

iTriage: The iTriage application gives smart phone and computer users access to a symptom navigator which assists users in finding nearby health facilities or physicians that could help with their specific health issue. iTriage assists users in finding health care that is right for them.

Provider Networks

We contract with physicians, hospitals and other health care providers for services they provide to our members. The health care providers who participate in our networks are independent contractors and are neither our employees nor our agents, except for providers who work in our mail-order and specialty pharmacy facilities.

We use a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with health care providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with our providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality.

At December 31, 2016, Aetna's underlying nationwide provider network had approximately 1.3 million participating health care providers, including over 702,000 primary care and specialist physicians and approximately 5,700 hospitals.

- Advanced Provider Models: We collaborate with hospitals and other providers through our APM products. Our arrangements focus on high value narrow network solutions to provide high-quality, low-cost options in local geographies. We are able to help enhance our relationships with hospitals and other providers through a variety of methods, including a re-alignment of financial incentives for providing high quality care, total cost management initiatives and risk sharing arrangements.
- Primary Care Physicians: We compensate primary care physicians ("PCPs") participating in our networks on both a fee-for-service and capitated basis, with capitation generally limited to HMO products in certain geographic areas and representing approximately 4 percent of health care costs in both 2016 and 2015 and 5 percent of health care costs in 2014. In a fee-for-service arrangement, physicians are paid for health care services provided to the member based upon a set fee for the services provided. Under a capitation arrangement, physicians receive a monthly fixed fee for each member, regardless of the volume of health care services provided to the member. In some cases, PCPs who are paid on a fee-for-service or capitated basis also receive additional incentive fees if certain performance metrics are attained.
- Specialist Physicians: Specialist physicians participating in our networks are generally reimbursed at contracted rates per visit or per procedure.
- Hospitals: We typically enter into contracts with hospitals that provide for per-day and/or per-case rates, often with fixed rates for ambulatory, surgery and emergency room services. We also have hospital contracts that provide for reimbursement based on a percentage of the charges billed by the hospital. Our medical plans generally require notification of elective hospital admissions, and we monitor the length of hospital stays. Physicians who participate in our networks generally admit their patients in network-based products to participating hospitals using referral procedures that direct the hospital to contact our patient management unit in order to confirm the patient's membership status and facilitate the patient management process. This unit also assists members and providers with related activities, including, if necessary, the subsequent transition to the home environment and home care. Case management assistance for complex cases is provided by a special unit.
- Other Providers: Laboratory, imaging, urgent care and other freestanding health facility providers are generally paid under fee-for-service arrangements, except for certain laboratory services.

Quality Assessment

CMS uses a 5-star rating system to monitor plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers

a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. Refer to “Pricing” below in this Item 1 for further discussion of our star ratings.

We seek Health Plan accreditation for our Aetna HMO plans from the National Committee for Quality Assurance (the “NCQA”), a national organization established to review the quality and medical management systems of health care plans. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of Aetna, has received nationwide NCQA PPO Health Plan accreditation, through December 13, 2019. As of December 31, 2016, all of our Aetna Health Inc. Commercial HMO and ALIC PPO members who were eligible, participated in HMOs or PPOs that are accredited by the NCQA.

NCQA and URAC (formally known as American Accreditation HealthCare Commission, Inc.), are national organizations founded to establish standards for the health care industry. Purchasers and consumers look to URAC's and NCQA's accreditation and certification as an indication that a health care organization has the necessary structures and processes to promote high-quality care and preserve patient rights. In addition, regulators in over 80% of the states recognize NCQA's accreditation and certification standards.

Our provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, we are certified under the NCQA Credentials Verification Organization (“CVO”) certification program for all certification options through January 5, 2019. Our URAC CVO accreditation is valid through October 1, 2018.

Our quality assessment programs for contracted providers who participate in our networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by us or in some cases by the practitioner's affiliated group or organization. We generally require participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

We also offer quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Principal Markets and Sales

Our medical membership is dispersed throughout the U.S., and we serve a limited number of members in certain countries outside the U.S. Refer to Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our foreign customers. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, we market to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by U.S. and other geographic region and funding arrangement at December 31, 2016, 2015 and 2014:

	2016			2015			2014		
(Thousands)	Insured	ASC	Total	Insured	ASC	Total	Insured	ASC	Total
Northeast	2,121	2,966	5,087	2,166	2,952	5,118	2,314	2,905	5,219
Southeast	2,260	3,076	5,336	2,173	3,183	5,356	2,149	3,167	5,316
Mid-America	2,506	2,673	5,179	2,507	2,913	5,420	2,372	2,980	5,352
West	1,954	4,848	6,802	1,837	5,008	6,845	1,999	4,950	6,949
Other	331	375	706	440	308	748	452	260	712
Total medical membership	9,172	13,938	23,110	9,123	14,364	23,487	9,286	14,262	23,548

Additional information on Health Care's membership is included in the “Healthcare - Membership” section of the MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

We market both Commercial Insured and ASC products and services primarily to employers that sponsor our products (also called “plan sponsors”) for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. We also sell Insured plans directly to individual consumers in a number of states, including through Public Exchanges. Some Health Care products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly.

We offer Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. We also offer Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care products are sold through our sales personnel; through independent brokers, agents and consultants who assist in the production and servicing of business; and Insurance Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, we may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. In certain cases, our customer pays the broker for services rendered, and we may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. We support our marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

Pricing

For Commercial Insured plans, including our Public Exchange plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under our ASC plans are generally fixed for a period of one year.

We use prospective rating methodologies in determining the premium rates charged to the majority of employer groups, and we also use retrospective rating methodologies for a limited number of groups. Premium rates for customers with more than approximately 125 employees generally take into consideration the individual plan sponsor's historical and anticipated claim experience where permitted by law. Some states may prohibit the use of one or more of these rating methods for some customers, such as small employer groups, or all customers.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We typically cannot recover unanticipated increases in health care costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Our future operating results could be adversely affected if the premium rates we request are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, in certain instances we may recover the resulting deficit through contractual provisions or consider the deficit in setting future premium levels. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating may be used for Commercial Insured plans that cover more than approximately 300 lives.

We have Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays us a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. Our PDP contracts also provide a risk-sharing arrangement with CMS to limit our exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to us under the Medicare arrangements are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Premiums paid to us for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS,

some of our Medicare Advantage products and all of our PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial products, Medicare contracts generate higher per member per month revenues and health care costs.

The ACA ties a portion of each Medicare Advantage plan’s reimbursement to the plan’s “star ratings.” Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released our 2017 star ratings in October 2016. Our 2017 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2018. Based on our membership at December 31, 2016, 92% of our Medicare Advantage members were in plans with 2017 star ratings of at least 4.0 stars, compared to 85% of our Medicare Advantage members being in plans with 2016 star ratings of at least 4.0 stars based on our membership at December 31, 2015.

Rates for our Medicare Supplement products are regulated at the state level and vary by state and plan.

Under our Insured Medicaid contracts, state government agencies pay us fixed monthly rates per member that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. We also receive fees from our customers where we provide services under ASC Medicaid contracts. Our ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and our financial risk share obligations are typically limited to a percentage of the fees otherwise payable to us. Payments to us under our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under our Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if we fail to comply with CMS regulations or other contractual requirements.

We offer HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes. In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the ACA’s health insurer fee (the “HIF”). Refer to Note 2 “Summary of Significant Accounting Policies” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the ACA fees, assessments and taxes. Our goal is to collect in premiums and fees or solve for all of these estimated fees, assessments and taxes.

Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Public and Private Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and do not indicate that these companies are our only competitors or are our closest competitors.

We believe that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. We believe that we are competitive on each of these factors. Our ability to increase the number of persons covered by our plans or to increase our revenues is affected by our ability to differentiate ourselves from our competitors on these factors. Competition may also affect the

availability of services from health care providers, including primary care physicians, specialists and hospitals.

Our Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. Our largest competitor in our Medicare products is Original Medicare. Additional competitors include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures, technology firms, financial services firms that are distributing competing products on their

proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. Our ability to increase the number of persons enrolled in our Insured products also is affected by the desire and ability of employers to self-fund their health coverage.

Our ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and third-party administrators.

Our international products compete with local, global and U.S. based health plans and commercial health care benefit insurance companies, many of whom have a longer operating history and better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and provider solutions and HIT products are evolving rapidly. We compete for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many of our information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting our ability to obtain new customers or retain existing customers, our membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the U.S. and industries where our membership is concentrated.

Reinsurance

We currently have several reinsurance agreements with non-affiliated insurers that relate to Health Care insurance policies. We entered into these contracts to reduce the risk of catastrophic losses which in turn reduces our capital and surplus requirements. We frequently evaluate reinsurance opportunities and refine our reinsurance and risk management strategies on a regular basis.

Group Insurance Segment

Principal Products

Group Insurance products consist primarily of the following:

- Life Insurance: Our life insurance products principally consist of group term life insurance, the amounts of which may be fixed or linked to individual employee wage levels. We also offer voluntary spouse and dependent term life insurance, and group universal life and accidental death and dismemberment insurance. We offer life insurance products on an Insured basis.
- Disability Insurance: Our Disability products provide employee income replacement benefits for both short-term and long-term disability (and products which combine both). Similar to Health Care products, we offer disability benefits on both an Insured and employer-funded basis. We also provide absence management services to employers, including short-term and long-term disability administration and leave management.
- Long-Term Care Insurance: Our Long-Term Care Insurance products provide benefits to cover the cost of care in private home settings, adult day care, assisted living or nursing facilities. We no longer solicit or accept new long-term care customers. Long-term care benefits were offered primarily on an Insured basis. The product was available on both a service reimbursement and disability basis.

Principal Markets and Sales

We offer our Group Insurance products in 49 states as well as Washington, D.C., Guam, Puerto Rico, the U.S. Virgin Islands and Canada. Depending on the product, we market to a range of customers from small employer groups to

large, multi-site and/or multi-state employer programs.

We market Group Insurance products and services primarily to employers that sponsor our products for the benefit of their employees and their employees' dependents. Frequently, employers offer employees a choice of benefits, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Group Insurance products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly.

Group Insurance products are sold through our sales personnel, as well as through independent brokers, agents and consultants who assist in the production and servicing of business. For large plan sponsors, independent consultants and brokers are frequently involved in employer plan selection decisions and sales. We pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. We support our marketing and sales efforts with an advertising program that may include direct marketing efforts as well as television, radio, billboards, print media and social media, supplemented by market research.

Pricing

For Insured and employer-funded Group Insurance plans, employer group contracts containing the pricing and other terms of the relationship are generally established in advance of the policy or contract period. We use prospective and retrospective rating methodologies to determine the premium rates charged to employer groups on our Insured products. Contracts are typically offered with rate guarantees that generally range from one to five years.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We typically cannot recover unanticipated increases in mortality or morbidity costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, we consider the deficit in setting future premium levels, and in certain instances, we may recover the deficit through contractual provisions such as offsets against refund credits that develop for future policy periods. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating is most often used for Insured plans that cover more than approximately 3,000 lives.

Competition

For the group insurance industry, we believe that the significant factors that distinguish competing companies are cost, quality of service, financial strength of the insurer, comprehensiveness of coverage, and product array and design. We believe we are reasonably competitive on each of these factors; however, some of our competitors have greater scale, financial and other resources, better brand recognition and lower expenses. The group life and group disability marketplaces remain highly competitive.

Reinsurance

We currently have several reinsurance agreements with non-affiliated insurers that relate to both life and long-term disability products. Certain of our reinsurance arrangements are established on a case-by-case basis, and a subset of our reinsurance agreements cover closed blocks of business and canceled cases. We also have a reinsurance arrangement to mitigate long-term disability claim severity risk at the individual claim level, and another reinsurance arrangement that provides a limited degree of catastrophic risk protection for certain of our life products. We frequently evaluate reinsurance opportunities and refine our reinsurance and risk management strategies on a regular basis.

Large Case Pensions Segment

Principal Products

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. We do not actively market Large Case Pensions products, but continue to accept deposits from existing customers and manage the run-off of our existing business. Contracts provide non-guaranteed, experience-rated and guaranteed investment options through general and separate account products. Large Case Pensions products that use separate accounts provide contract holders with a vehicle for investments under which the

contract holders primarily assume the investment risk. Large Case Pensions earns a management fee on these separate accounts.

In 1993, we discontinued our fully-guaranteed Large Case Pensions products. Refer to Note 19 “Discontinued Products” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

Other Matters

Access to Reports and Other Information

Our reports to the U.S. Securities and Exchange Commission (the "SEC"), including our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and any amendments to those reports are available without charge on our website at www.aetna.com as soon as practicable after they are electronically filed with or furnished to the SEC. The information on or linked to our website is neither a part of nor incorporated by reference in this Annual Report on Form 10-K or any of our other SEC filings. Copies of these reports are also available, without charge, from Aetna's Investor Relations Department, 151 Farmington Avenue, Hartford, CT 06156.

You also can download from our website our articles of incorporation, by-laws and corporate governance policies, including our Corporate Governance Guidelines, the charters of the key standing Committees of our Board of Directors and our Code of Conduct. Copies of these documents are also available, without charge, from Aetna's Corporate Secretary, 151 Farmington Avenue, RW61, Hartford, CT 06156.

Our transfer agent, Computershare Trust Company, N.A., can help with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person or other administrative services. Shareholders can write to our transfer agent by mail at P.O. Box 30170, College Station, TX 77842-3170 or contact them by telephone at 1-800-446-2617.

Regulation

For information regarding significant regulation that affects us, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K and for a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with regulation that affects us, see "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K.

Patents and Trademarks

We own a number of trademarks and patents that are important to Aetna. Some of the trademarks include Aetna, as well as the corresponding Aetna design logo, Aetna Navigator®, ActiveHealth®, bswift®, CareEngine®, Coventry®, DocFind®, Healthagen®, Healthy Merits®, iTriage®, Medicity®, Meritain Health®, NeoCare Solutions®, PayFlex®, Practice IQ®, Prodigy Health Group®, Springboard Marketplace® and Wellmatch®. Some of our patents include the CareEngine patent that expires in 2021 and the Master Patient Index patent that expires in 2029. We consider these patents and trademarks and our other patents, trademarks and trade names important in the operation of our business. However, our business, including that of each of our individual segments, is not dependent on any individual patent, trademark or trade name.

Employees

We had approximately 49,500 employees at December 31, 2016.

Customer Concentration

The U.S. federal government is a significant customer of both the Health Care segment and the Company as described below:

- Premiums and fees and other revenue paid by the federal government accounted for 34% of the Health Care segment's revenue and 33% of our consolidated total revenue in 2016.

- Contracts with CMS for coverage of Medicare-eligible individuals accounted for 82% of our federal government premiums and fees and other revenue, with the balance coming from federal employee-related benefit programs and ACA programs. No other individual customer, in any of our segments, accounted for 10% or more of our consolidated total revenue in 2016.

- Our Medicaid products accounted for 13% of both the Health Care segment's revenue and our consolidated total revenue in 2016. However, no individual state government agency accounted for more than 10% of our consolidated total revenue or the Health Care segment's revenue in 2016.

Other than our contracts with CMS, our segments are not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of a segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on our earnings or the earnings of any of our segments. Refer to Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

Item 1A. Risk Factors

Risk Factors

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this Annual Report on Form 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this Annual Report on Form 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect our business. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, these events or circumstances could have a material adverse effect on our business, cash flows, financial position or operating results. In that case, the trading price of our common stock could decline materially, among other effects on us.

Effectiveness of our enterprise strategy, talent management and alignment of talent to our business needs and risks to our brand and reputation present overarching risks to our enterprise in 2017.

We expect to face significant business challenges and uncertainties in 2017. Effectiveness of our enterprise strategy, talent management and alignment of talent to our business needs and risks to our brand and reputation present overarching risks to our enterprise in 2017. There can be no assurance regarding the effectiveness of our enterprise strategy, our ability to manage and align our talent to our business needs or our ability to avoid harm to our brand and reputation. In addition, there can be no assurance that U.S. government fiscal policy, the implementation of the ACA, repeal or other changes to the ACA or additional changes to the U.S. health care system will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our business, cash flows, financial position or operating results.

While we consider the foregoing to be the overarching risks we face in 2017, they are not the only material risks we face. We face numerous other challenges, as described elsewhere in this Annual Report, including below in this “Risk Factors” discussion, and other unanticipated risks may develop.

Our enterprise strategy may not be an effective response to the changing dynamics in the health and related benefits industry, or we may not be able to implement our strategy and related strategic projects.

Our strategy includes effectively investing our capital and human resources in appropriate strategic projects, current operations and acquisitions to transform our business in response to the changing dynamics in the health and related benefits industry, including the evolution toward a direct-to-consumer marketing and operating model, the declining number of commercially insured people and the potential shift to a defined contribution model for health benefits. Our strategic projects include, among other things: significant investments in human and technology resources to expand our Consumer Health and Services product line, including to develop and expand our consumer business, and compete effectively in a direct-to-consumer marketplace; transforming our business model through consumer engagement, joint ventures, ACOs and collaborative provider networks; participating in select Public Exchanges and Private Exchanges (collectively, “Insurance Exchanges”); optimizing our business platforms; managing certain significant technology projects; further improving relations with health care providers; negotiating contract changes with customers and providers; and implementing other business process improvements. Implementing our strategic initiatives will require significant investments of capital and human resources. Among other things, we will need to simultaneously acquire and develop new personnel, products and systems to serve existing and new customers with

existing and new products, our consumer business, which began serving members on January 1, 2016, and enhance our existing customer service, information technology, control and compliance processes and systems. The future performance of our businesses will depend in large part on our ability to design and implement our strategic initiatives, some of which will occur over several years. If these initiatives do not achieve their objectives, our operating results could be adversely affected.

Our enterprise strategy may not be an effective response to the changing dynamics in the health and related benefits industry, and we may fail to recognize and position ourselves to capitalize upon market opportunities. We may not have sufficient advance notice and resources to develop and effectively implement an alternative strategy. Competitors who develop a superior strategy, or more effectively implement their strategy, may develop capabilities, competitive advantages and competitive positions that are difficult to match or overcome.

We are dependent on our ability to recruit, retain and develop a very large and diverse workforce. We must transform our culture in order to successfully grow our business.

Our products and services and our operations require a large number of employees. A significant number of employees have joined us in recent years as a result of our acquisitions and our entry into new businesses. Our success is dependent on our ability to transform our culture, align our talent with our business needs, engage our employees and inspire our employees to be open to change, to innovate and to maintain consumer-focus when delivering services to our customers. Our business would be adversely affected if we fail to adequately plan for succession of our executives and senior management; or if we fail to effectively recruit, integrate, retain and develop key talent and/or align our talent with our business needs, in light of the current rapidly changing environment. While we have succession plans in place and we have employment arrangements with a limited number of key executives, these do not guarantee that the services of these or suitable successor executives will continue to be available to us. In addition, as we expand internationally, we face the challenge of recruiting, integrating, educating, managing, retaining and developing a more culturally diverse workforce.

Our brand and reputation are two of our most important assets; negative public perception of the health and related benefits industry, or of the industry's or our practices, can adversely affect our operating results.

The health and related benefits industry regularly is negatively perceived by the public and subject to negative publicity, including as a result of the ongoing public debate over the future of the ACA, proposed transactions in our industry (including the Humana Acquisition and related litigation), governmental investigations and actual or perceived shortfalls regarding the industry's or our own products and/or business practices (including withdrawing from participation in Public Exchanges and social media activities). This risk may be increased as the federal government continues to consider alternatives to amend, repeal and/or replace the ACA (including Medicaid expansion) and as states seek to maintain, replace or repeal elements of the ACA such as Public Exchanges and Medicaid expansion within increasingly challenging budget constraints. This risk will increase further if we implement significant increases in premium rates to price for additional risk and/or expanded benefits resulting from, and fees, assessments and taxes imposed by, the federal and state governments as well as any acceleration in medical cost inflation. This risk may be increased as states and the federal government continue to debate the ACA and implement any amendment, repeal or replacement of the ACA, as we continue to offer products that make greater use of data and products (including products for people who are eligible for Medicare or Medicaid or dually eligible for Medicare and Medicaid) beyond those in our core Commercial business and as our business model becomes more focused on consumers and direct-to-consumer sales, including as a result of us developing and expanding our Consumer Health and Services product line, competing for sales on select Insurance Exchanges and withdrawing from participation on most individual Public Exchanges. Significant reductions or interruptions in funding for government health programs we serve also may lead us to reduce our exposure to these programs, which could adversely affect our brand and reputation.

Negative public perception and/or publicity of the health and related benefits industry in general, or us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- Adversely affecting our brand and reputation;
- Adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- Requiring us to change our products and/or services; and/or
- Increasing or significantly changing the regulatory and legislative requirements with which we must comply.

Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy (in respect of the ACA or otherwise) that can adversely affect the markets for our products and services and our business, operations and operating results.

The political environment in which we operate remains uncertain, including as a result of the new U.S. presidential administration and the control of the U.S. Congress by a single political party. It is reasonably possible that our business operations and operating results could be materially adversely affected by public policy changes at the state or federal level, which include amendment, repeal or replacement of the ACA but also extend to many other public policy initiatives. Such changes may present us with new financial and other challenges, which may, for example, cause membership in our health plans to decrease or make doing business in particular states less attractive. If we fail to adequately respond to such changes, including by implementing effective operational and strategic initiatives, or do not do so as effectively as our competitors, our business, operations and operating results may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our business. At the federal level these proposals include changes in the funding levels and/or design of federally-supported benefit programs, changes in payment methodologies for health plans and/or providers under Medicare and substantial change in the regulations governing our business. At the state level, these proposals include mandating pharmacy benefits; expanded provider network requirements; significant new fees, assessments and taxes on payors, including in response to reduced federal funding or other state budgetary pressures; mandating lower out of pocket costs for members; and raising Medicaid minimum MLR thresholds above 85%, instituting profit caps on Medicaid contracts and changing the designs of state Medicaid programs. The federal and many state governments are also considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including substantial changes to federal funding of state Medicaid programs. At the state level, all 50 U.S. states and the District of Columbia will hold regular legislative sessions in 2017. In 2016, state legislatures focused on state budgets and taxes (including new assessments on health care premiums), provider network composition and provider directory accuracy requirements, pharmacy benefit and drug coverage requirements, Medicaid reforms and health care delivery system transformation. We expect state legislatures to focus on these issues again in 2017, as well as the adverse impact of expected changes to the ACA and other federal programs on state programs and budgets.

We cannot predict the enactment or content of new legislation and regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of our industry. Examples of such change include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, or dual eligible programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes is increasing due to state and federal budgetary pressures, and our business and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence. For more information on these matters, refer to “Regulatory Environment” of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

The ACA may be repealed or amended. If the ACA is not amended or repealed, certain aspects of the ACA as currently enacted have yet to take full effect, are unclear, or are subject to effective amendment through the implementation process, making their practical effects difficult to predict. Our business and operating results may be materially and adversely affected by the ACA and/or changes to the ACA even if we correctly predict their effects.

If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2020. Potential repeal of the ACA, ongoing legislative and regulatory changes to the ACA, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of the ACA (including risk corridors and the ACA’s Cost Sharing Subsidy program), the results of the 2016 presidential, congressional and state level elections, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Examples of recent legislative and regulatory changes include: the January 20, 2017 executive order relating to the ACA; the November 2016 HHS announcement that risk corridor collections for the 2015 program year will be applied first to amounts owed to plans for the 2014 program year; the May 2016 final regulations relating to the ACA’s non-discrimination requirements; the December 2015 suspension of the ACA’s health insurer fee (the “HIF”) for 2017 and two year delay of the “Cadillac” tax on high-cost employer-sponsored health coverage; the October 2015 PACE, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that ACA risk corridor receivables for the 2014 program year would only be funded at 12.6%.

We expect the 2017 suspension of the HIF to adversely affect our 2017 revenues and MBRs compared to 2016 as this change was reflected in reduced premiums for 2017 medical customer renewals. In addition, there is some uncertainty whether we will be able to include all of our portion of the industry-wide $14.3 billion 2018 HIF (as currently enacted) in our premium rates beginning with 2017 medical customer renewals that have member months in 2018, particularly following the HIF suspension for 2017.

The pending litigation challenging the ACA includes the House of Representatives' challenge to HHS's ability to make payments under the ACA's Cost Sharing Subsidy program without an explicit appropriation. The time frame for conclusion, final outcome and ultimate impact of this litigation are uncertain. A final ruling that adversely impacts the Cost Sharing Subsidy program could cause significant adverse selection in individual Public Exchange products and instability in the individual Public Exchange marketplace and could have a material adverse effect on our business, cash flows, financial condition and operating results as well as hinder our ability to offer Public Exchange products.

While most of the significant aspects of the ACA became effective during or prior to 2014, as currently enacted, certain components of the ACA will continue to be phased in through 2020. In addition, significant parts of the ACA, including aspects of non-discrimination requirements, continue to evolve through the promulgation of executive orders, regulations and guidance. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response to repeal or replacement of or changes to the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us.

Accordingly, even in the absence of any amendment or repeal, many of the specific aspects and impacts of the ACA as currently enacted will not be known for several years, and given the inherent difficulty of foreseeing how individuals and businesses will respond to the choices afforded to them by the ACA, we cannot predict the full effect of the ACA or the impact of future changes to the ACA on us. Further, even if we correctly predict how parts of the ACA will develop or change and affect us, our business and operating results may still be materially and adversely affected. For example, we anticipate that some aspects of the ACA and other existing measures and new measures, if enacted, could materially adversely affect our Health Care and/or Group Insurance operations and/or operating results by, among other things:

- Reducing our ability to obtain adequate premium rates for the risk we assume (including denial of or delays in obtaining regulatory approval for and implementation of those rates);
- Significantly reducing the level or changing the design of Medicare and/or Medicaid program payments;
- Adversely affecting the stability of the individual insurance marketplace;
- Restricting our ability to price for the risk we assume and/or reflect reasonable costs or profits in our pricing, and/or limiting the level of margin we can earn, including by mandating minimum medical loss ratios;
- Reducing our ability to manage health care or other benefit costs (including by mandating benefits, restricting our ability to manage our provider network and/or capping member cost sharing or otherwise limiting members' financial responsibility for health care or other covered services they utilize and thus increasing our medical costs);
- Increasing health care or other benefit costs and operating expenses (including duplicate expenses resulting from changes in regulations during implementation);
- Increasing our exposure to lawsuits and other adverse legal proceedings;
- Adversely affecting our product mix;
- Imposing new or increasing existing taxes and financial assessments; and/or
- Increasing the general and administrative expenses of our Group Insurance business relative to its competitors.

Legislative and regulatory changes could create significant challenges to our Medicare Advantage and PDP revenues and operating results, and proposed changes to these programs could create significant additional challenges. Starting in 2017, federal funding for Medicaid expansion will decrease. Entitlement program reform, if it occurs, could have a material adverse effect on our business, operations or operating results.

From time to time the federal government alters the level of funding for government health care programs, including Medicare. Under the Budget Control Act of 2011 (the "BCA") and the American Taxpayer Relief Act of 2012 (the "ATRA"), significant, automatic across-the-board budget cuts (known as sequestration) to several federal government programs started in March 2013. These include Medicare spending cuts of up to 2% of total program costs per year through 2024. The ATRA also contained additional reductions to Medicare reimbursements to health plans that commenced in April 2013 and eliminated funding for certain ACA programs. These reductions could adversely affect us, our customers and our providers.

Medicare Advantage payment rates to health plans have been cut over the last several years, with additional reductions to be phased in through 2017. CMS's April 2016 final notice for Medicare Advantage benchmark payment rates (the

"Final Notice") provides for rate cuts to the employer group waiver program that will begin in 2017 and be fully phased in for 2018 as well as adverse changes to the risk adjustment mechanism for dual eligible beneficiaries and the Medicare Advantage star rating program. Overall, we project the benchmark rates for 2017 in the Final Notice will decrease funding for our Medicare Advantage business by less than 1 percent in 2017 compared to 2016. This 2017 rate decrease adds to the challenge we face from the impact of the increasing cost of medical care, the HIF beginning in 2018 (as currently enacted) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on the Medicare Advantage program and our Medicare Advantage operating results. We cannot predict

future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare operating results.

In addition, the "star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by compliance issues that arise in our Medicare operations, such as our distribution of inaccurate information regarding which pharmacies were part of our Medicare network and related $1 million civil monetary penalty in 2015 and notices of non-compliance and warning letters in 2016. During 2016, our star ratings resulted in additional revenue of approximately $560 million, inclusive of bonus payments and rebates. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues and operating results may be significantly adversely affected.

In April 2016, CMS issued a final rule that overhauls the entire Medicaid managed care delivery system. The final rule represents the first update to Medicaid managed care regulations since 2002. Among other things the final rule requires Medicaid managed care products to have a minimum MLR of 85%; establishes a Medicaid managed care quality rating system; and establishes provider network adequacy requirements. The minimum MLR requirements are effective beginning in 2017.

Beginning in 2017, federal funding for expanded Medicaid coverage is decreasing, which is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our Government medical benefit ratio and our operating results.

We anticipate extensive debate concerning entitlement program reform in 2017, particularly over the federal government's funding of the Medicaid program. If entitlement program reform occurs, it could have a material adverse effect on our business, operations or operating results, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results.

We may not be able to obtain adequate premium rate increases, which would have an adverse effect on our revenues, medical benefit ratios and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases of 10% or more (or another state-specific threshold set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. The risk of increases in utilization of medical and/or other covered services and/or in health care and other benefit costs is particularly acute during and following periods, when utilization has been below recent historical levels, during periods of changing economic conditions and/or employment levels and in products where there is significant turnover in our membership each year, such as Public Exchanges. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and/or CHIP premium rates is limited due, among other things, to the budgetary pressures currently facing many state governments. This could magnify the adverse impact on our operating margins and operating results of increases in utilization of medical and other covered services, health care and other benefit costs

and/or medical cost trends that exceed our projections.

Since 2013, HHS has issued determinations to health plans that their rate increases were “unreasonable,” and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also have conducted hearings on proposed premium rate increases, which can result, in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in Public Exchanges if they are deemed to have a history of “unreasonable” rate increases. We requested significant increases in our premium rates in our individual and small group Health Care businesses for 2017 and expect to continue to request significant increases in those rates for 2018 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for the applicable products (also

known as “adverse selection”) in our products, particularly in individual and small group products, which we expect to continue and potentially worsen in 2017 with the expiration of the ACA’s risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory reaction and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured business. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in any product line or geography. If we are unable to obtain adequate rates and/or rate increases, it could materially and adversely affect our operating margins and our ability to earn adequate returns on Insured business in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured, Medicare Insured and Medicaid Insured businesses while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA requires us to pay minimum MLR rebates each year with respect to prior years. The ACA’s minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. Refer to “Revenue Recognition” in Note 2 “Summary of Significant Accounting Policies” included in Part II, Item 8 of this Annual Report on Form10-K for more information. Certain portions of our Medicaid and Federal Employees Health Benefits (“FEHB”) program business are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the rebate reporting requirements are detailed. Federal and state auditors are challenging our Commercial business compliance with the ACA’s minimum MLR requirements, and our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years (including on a retrospective basis), it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years (including on a retrospective basis), it will be terminated by CMS. Federal auditors also are challenging our FEHB plans’ compliance with the Office of Personnel Management’s (“OPM’s”) FEHB program specific minimum MLR requirements. Additional challenges to our methodology and/or reports relating to minimum MLR rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Additionally, we are required to pay minimum MLR rebates in a number of states in which we offer Medicaid coverage. In 2017, there also are pending proposals in a number of states to raise Medicaid minimum MLR thresholds above 85% and/or institute profit caps on state Medicaid contracts. These rebates and proposals are not required by the ACA; they are mandated by our Medicaid contracts or applicable state laws or regulations.

We may be subject to regulatory actions or suffer brand and reputational harm if we do not or cannot adequately implement the ACA, any amendment, repeal or replacement of the ACA and/or related legislation or regulations, which may have a material adverse effect on our business.

We are dedicating, and will continue to be required to dedicate significant resources and incur significant expenses to implement and comply with the ACA as currently enacted and any amendment, repeal or replacement of the ACA and/or related legislation or regulations at both the state and federal level, including complying with the implementation timeframe set by the government each year for developing and pricing our Public Exchange products

for the following year and implementing as well as complying with future legislation and regulations that will provide guidance on and clarification of and changes to significant parts of the legislation. If we fail to effectively implement the ACA and changes to, or repeal or replacement of, the ACA and/or related legislation or regulations and our related operational and strategic initiatives, or do not do so as effectively as our competitors, our business, operating results, brand and reputation may be materially adversely affected, we may lose customers and we may be subject to penalties, sanctions or other regulatory actions.

If we are unable to include the significant assessments, fees and taxes imposed on us by the ACA or otherwise by federal or state governments in our premiums and fees or otherwise solve for them, our operating results, financial position and/or cash flows would be materially and adversely affected. The inclusion of these assessments, fees and taxes in our premiums also could adversely affect our ability to grow and/or maintain our medical membership.

The ACA imposes significant assessments, fees and taxes on us and other health insurers, health plans and other industry participants. There is some uncertainty whether we will be able to include all of these assessments, fees and taxes in our premium rates. It may be particularly challenging to be able to include all of our portion of the industry-wide $14.3 billion 2018 HIF (as currently enacted) in our premium rates beginning with 2017 medical customer renewals that have member months in 2018 because of the HIF suspension for 2017. Our ability to reflect the ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and CHIP rates is limited due, among other things, to the budgetary pressures currently facing many state governments.

We cannot predict the nature or extent of any new or increased federal or state assessments, fees or taxes associated with changes in the ACA or state actions in 2017 or thereafter. Those new or increased assessments, fees or taxes may be significant. If we are unable to include assessments, fees and taxes in our premiums and fees or otherwise adjust our business model to solve for them, these assessments, fees and taxes could have a material adverse effect on our operating results, financial position and/or cash flows. The increases in our prices caused by including all of these assessments, fees and taxes in our premiums and fees also could adversely affect our ability to profitably grow and/or maintain our medical membership, for example, if our competitors do not seek to include all or a significant portion of these assessments, fees and taxes in their premiums or fees.

Our business activities are highly regulated. Our Medicare, Medicaid, specialty and mail order pharmacy, Public Exchange and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our business. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.

Our business is subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently (as evidenced by amendments to, and possible repeal or replacement of, the ACA and the continuing administrative changes in, and pending litigation regarding, the implementation of the ACA as well as other new federal and state laws and regulations), and can be inconsistent or conflicting. In general, these laws and regulations are designed to benefit and protect members and providers rather than us or our investors. In addition, the governmental authorities that administer our business have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year.

Our Medicare, Medicaid, dual eligible, Public Exchange, specialty pharmacy and mail order pharmacy products are more highly regulated than our other Health Care products. The laws and regulations governing participation in Medicare, Medicaid and dual eligible programs are complex, are subject to interpretation and can expose us to penalties for non-compliance, including penalties under the federal false claims act (the “False Claims Act”) and state false claims acts. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products sold on Public Exchanges. The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a qui tam or “whistleblower” suit. If we are convicted of fraud or other criminal conduct in the performance of a health program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare, Medicaid and dual eligible programs, and we also may be required to pay significant fines and/or other monetary penalties.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members,

corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare, Medicaid, dual eligible and other programs, cash flows, financial position and operating results. For example, CMS assessed a civil monetary penalty of $1 million against us in 2015 for distributing inaccurate information regarding which pharmacies were part of our Medicare network. Also, from April 2010 through June 2011, we were subject to intermediate sanctions that CMS imposed on us that required us to suspend the enrollment of and marketing to new members of all Aetna Medicare Advantage and PDP contracts. As a result of these sanctions, our 2011 Medicare membership and operating results were adversely affected because we did not participate in the annual enrollment process for 2011 and were not again eligible to receive automatic assignments of low income subsidy PDP members from CMS until September 2012.

Our products providing PBM and specialty and mail order pharmacy services are subject to:

- The risks inherent in the dispensing, packaging and distribution of pharmaceuticals and other health care products, including claims related to purported dispensing and other operational errors (any failure by us or one of our PBM

services suppliers to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our PBM and/or pharmacy subsidiaries to civil and criminal penalties).

- Federal and state anti-kickback and other laws that govern our relationship with pharmaceutical manufacturers, customers and consumers.
- Compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings.
- Federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices, including the management and breadth of provider networks, the regulation of the development and use of drug formularies (such as the 2014 regulatory activity requiring us and certain other payors to place certain high cost drugs in preferred positions in our drug formularies) and/or maximum allowable cost list pricing, legislation, regulations or regulatory activity increasing the regulation of prescription drug pricing, imposing additional rights to access to drugs for individuals enrolled in health care benefit plans or reducing the cost of such drugs to those individuals, the receipt or required disclosure of rebates from pharmaceutical manufacturers, and restrictions on the use of average wholesale prices.

Our business, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations, including new legislation or regulations that apply to Private Exchanges. For more information regarding these matters, refer to “Regulatory Environment” of MD&A included in Part II, Item 7 and “Litigation and Regulatory Proceedings” in Note 17 “Commitments and Contingencies” included in Part II, Item 8 of this Annual Report on Form10-K.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices, and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national health and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. Several such audits, investigations and reviews currently are pending, some of which may be resolved in 2017, and the results of which may be adverse to us.

There continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry’s business and reporting practices, including premium rate increases, provider network adequacy, provider network directories, pharmacy formulary tiering, pharmacy network structures, utilization management and payment of providers with whom the payor does not have a contract and other health and life insurance claim payment practices. In addition, a significant number of states are investigating life insurers’ and health insurers’ claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlement agreements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance and health insurance claim payment and related escheat practices. Given the judicial, legislative and regulatory uncertainty with respect to life insurance and health insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows. For additional information on these life insurance matters, refer to “Regulatory Environment - Life and Disability Insurance” of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other market participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our self-insured customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. For example, CMS assessed a civil monetary penalty of $1 million against us in 2015. Any of these audits, investigations or reviews could have a material adverse effect on our financial position, operating results or business or result in significant liabilities and negative publicity for our company. Federal and state auditors are challenging our Commercial business compliance with the ACA's minimum MLR requirements. Our Commercial business has been subject to audits related to the ACA's risk adjustment and reinsurance data since those programs were implemented in 2014. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years (including on a retrospective basis), it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years (including on a retrospective basis), it will be terminated by CMS. Federal auditors are also challenging our FEHB plans' compliance with the OPM's FEHB program specific minimum MLR requirements. For more information on certain CMS and other audits, see "We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS" on page 25.

For more information regarding these matters, refer to "Regulatory Environment" of MD&A included in Part II, Item 7 and "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K..

If our compliance systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our business, cash flows, operating results or financial position.

Our businesses are subject to extensive and complex regulations, and many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems in place to ensure that we comply with all applicable legal, regulatory and contractual requirements. These systems are frequently reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our business, cash flows, operating results or financial position.

Our litigation and regulatory risk profile is changing as we offer new products and expand in business areas beyond our historical core business of providing Commercial managed care and health insurance products in the United States. Changes in the ACA at the federal or state level could accelerate that change.

Historically, we focused primarily on providing Commercial managed care and health insurance products in the United States. In comparison, our Medicare and Medicaid products were significantly smaller. In 2016, our Medicare and Medicaid products accounted for 48% of total Health Care premiums. Our business continues to change due to the following:

- Acquisitions: Our 2014 acquisition of InterGlobal expanded our international business.
- Expansion within the health care marketplace: We are expanding or seeking to expand our presence in various sectors of the health care marketplace, including Medicare, Medicaid, dual eligibles, international, and certain customers who are not subject to ERISA's limits on state law remedies and working to deliver innovative products in those sectors.

- Entry into new business and new product lines: We are in the process of developing and seeking to expand our Consumer Health and Services product line. Over the last several years we have entered into new product lines, including Insurance Exchanges, dual eligible programs, support services for ACOs, data analytics, recruitment for clinical trials and HIT.
- ACA Changes: Changes in the ACA at the federal or state level may create new products or expose us to new or expanded regulatory and/or litigation risk.

The increased volume of business in areas beyond our historical core business and new products subject us to litigation and regulatory risks that are different from the risks of providing Commercial managed care and health insurance products and increase significantly our exposure to other risks.

We are routinely subject to litigation and adverse legal proceedings, including class actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our business and operating results.

We are routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal proceedings arising in the ordinary course of our businesses. Certain of the lawsuits against us are purported to be class actions. The majority of these proceedings relate to the conduct of our health care operations and allege various violations of law. In addition, we operate in jurisdictions outside the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore more likely to be subject to dispute by customers, members, governmental authorities and others. We are incurring expenses to resolve these proceedings. The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur.

Litigation has been and may be brought against us by private individuals on behalf of the government through a qui tam or "whistleblower" suit. When a private individual brings a whistleblower suit, the defendant often will not be made aware of the suit for many months or even years, until the government commences its own investigation or determines whether it will intervene. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided under the Dodd-Frank Wall Street Reform and Consumer Protection Act increase the risk of whistleblower suits.

Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. For example, since 2007, we have been in class action litigation with non-participating providers over our payments to them, and during 2009, we settled a matter with the New York Attorney General that caused us to transition to different databases to determine the amount we pay non-participating providers under certain benefit plan designs. While we currently have insurance coverage for some 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 or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

Litigation and other adverse legal proceedings could materially adversely affect our business or operating results because of brand and reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. Refer to "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form10-K

Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our business. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our members, customers and other constituents in the ordinary course of our business. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the European Union's ("EU's") General Data Protection Regulation

which will apply across the EU effective May 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member information, whether by us, by one of our vendors or by another third party, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our brand and reputation, and could also result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our business, brand, reputation, cash flows and operating results.

Our business depends on our members' and customers' willingness to entrust us with their health related and other sensitive personal information. Events that negatively affect that trust, including inadequate disclosure to our members or customers our

uses of their information, failing to keep our information technology systems and our members' and customers' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates, vendors or other third parties, including our PBM services suppliers, could adversely affect our brand and reputation, membership and revenues and also expose us to mandatory disclosure to the media, litigation (including class action litigation) and other enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our business, cash flows, operating results or financial position. There can be no assurance that any such failure will not occur, or if any does occur, that we will detect it or that it can be sufficiently remediated.

We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS.

Premiums and/or fees for Medicare members, certain federal government employee groups and Medicaid beneficiaries are subject to retroactive adjustments and/or withholding by the federal and applicable state governments. Our Public Exchange business, including amounts payable to us or payable by us under the ACA's premium stabilization programs and our risk adjustment and reinsurance data, also is subject to audit by governmental authorities. CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members.

CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage plans for various contract years, including certain of the Company's plans for certain contract years, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The OIG also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers.

Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. In December 2015, CMS released a RFI for a significant expansion of the RADV audit program. As described in the RFI, CMS would use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive

refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would require us to change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. For additional information, refer to “Regulatory Environment - Medicare” of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K.

If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our financial position, cash flows and operating results.

CMS has issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our operating results, financial position or cash flows.

Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results, cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

Any premium or fee refunds, adjustments or withholding resulting from regulatory audits, whether as a result of RADV, Public Exchange related, recovery audit program or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows. For more information see "Regulatory Environment" of MD&A included in Part II, Item 7 of this Annual Report on Form10-K.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid and dual eligible programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us.

These risks are particularly high in our Medicare, Medicaid and dual eligible programs, where third parties perform pharmacy benefit management, medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of

which could adversely affect our business, cash flows, operating results or financial position. For more information on these matters, see “Our business activities are highly regulated. Our Medicare, Medicaid, specialty and mail order pharmacy, Public Exchange and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our business. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth” on page 21.

Programs funded by the U.S. federal government account for a substantial portion of our revenue and operating earnings. A delay by Congress in raising the federal government’s debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, operating results and cash flows.

The federal government's "debt ceiling", or the amount of debt the federal government is permitted to borrow to meet its legal obligations (including, among other things, interest on the national debt, Medicare and Medicaid premiums, Social Security benefits and contributions to the Federal Employees Health Benefits Program), is limited by statute and can only be raised by an act of Congress.

If Congress does not raise the debt ceiling before the federal government's current obligations approach or exceed its cash on hand and incoming receipts, federal government spending may be subject to delay, reduction, suspension or cancellation, including a federal government shutdown, which may be prolonged. A significant portion of our revenues are derived from health care coverage programs that are funded in whole or in part by the federal government, including the Medicare, Medicaid, and dual eligible programs, CHIP and the Federal Employees Health Benefits Program and subsidies for qualified individuals and families purchasing health insurance through Public Exchanges. If federal spending is delayed, suspended or curtailed, we would continue to receive claims from providers providing services to beneficiaries of these programs, and we could be liable for, and be required to fund, such claims. Furthermore, the terms of our disability products often provide that the benefits due to beneficiaries are reduced by the amount of certain federal benefits they receive, most notably Social Security Disability Insurance ("SSDI") payments. If such payments are suspended or reduced due to a failure to timely raise the debt ceiling, our disability payment obligations would be increased accordingly, and such increase could be material. If beneficiaries subsequently receive such payments from the federal government, we would seek reimbursement or attempt to offset a portion of such payments against future disability benefit payments. We may not be successful in recovering the amount sought. A failure to timely raise the debt ceiling could have a material adverse effect on our businesses, operating results, cash flows, brand and reputation and, in the case of a prolonged failure to raise the debt ceiling, our financial position.

If the United States defaults on its obligations due to a failure to timely raise the debt ceiling or otherwise, or its credit rating is downgraded by any of the credit rating agencies, interest rates could rise, financial markets could become volatile and/or the availability of credit (and short-term credit in particular) could be adversely affected, thereby increasing our borrowing costs, negatively impacting the value of our investment portfolio, and/or adversely affecting our ability to access the capital markets, which could have a material adverse effect on our operating results, financial position and cash flows and could adversely affect our liquidity.

Risks Related to Our Business

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our operating results. We may not able to obtain appropriate pricing on new or renewal business.

Premiums for our insured Health Care Products, which comprised 86% of our total consolidated revenues for 2016, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and healthcare utilization patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our operating results.

Our health care and other benefit costs can be affected by external events that we cannot forecast or project and over which we have little or no control, such as emerging changes in the economy and/or public policy, government mandated benefits or other regulatory changes, changes in our members' behavior and healthcare utilization patterns,

changes in health care practices, new technologies, increases in the cost of prescription drugs, direct-to-consumer marketing by pharmaceutical companies, clusters of high cost cases, influenza related health care costs (which may be substantial and are currently projected to be approximately the same in 2016-2017 as in 2015-2016), epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, as well as changes in provider billing practices. Our health care and other benefit costs also can be affected by changes in our business mix, product designs, contracts with providers, medical management, underwriting, rating and/or claims processing methods and processes, and our medical management initiatives may not deliver the reduction in utilization and/or medical cost trend that we project.

It is particularly difficult to accurately anticipate, detect, forecast, manage and reserve for medical cost trends and utilization of medical and/or other covered services during and following periods when such utilization and/or trends are below recent historical levels, during periods of changing economic conditions and employment levels and for products with substantial membership turnover such as Public Exchange products. For example, in the second and third quarters of 2016, we recorded

premium deficiency reserves totaling $85 million related to anticipated future losses for the 2016 coverage year in our individual Commercial products. Similarly, during calendar year 2014, medical costs in our smaller middle market and individual businesses were higher than we projected, and during the calendar years 2010-2013, medical costs and members' utilization of medical and/or other covered services were lower than we projected and members' utilization was below recent historical levels. We expect utilization to increase in 2017 when compared to 2016.

We have implemented price increases for 2017. If health care and other benefit costs are higher than the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our prices will not reflect the risk we assume, and our operating results will be adversely affected. If health care and other benefit costs are lower than we predict, our prices may be higher than those of our competitors, which may cause us to lose membership. For more information, see "Critical Accounting Estimates - Health Care Costs Payable" of MD&A included in Part II, Item 7 of this Annual Report on Form10-K.

Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and operating results will be negatively affected.

Our customer contracts are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and operating results.

In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and operating results, although such elections also may reduce our health care and other benefit costs.

In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an adverse and/or uncertain economy. These actions may adversely affect our membership, revenues and operating results.

If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care business, our operating results, financial position and cash flows could be materially and adversely affected.

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. Our businesses face significant competition in all of the geographies and product areas in which we operate. For example, our largest competitor in our Medicare products is Original Medicare. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods.

In our Health Care business, we compete on the basis of many factors, including perceived overall quality, quality of service, comprehensiveness of coverage, cost (including premium, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. Our competitors in our Health Care business include, among others, UnitedHealth Group Incorporated, Anthem, Inc., Humana Inc., Cigna Corporation, WellCare Health Plans, Inc., Centene Corporation, Molina Healthcare, Inc., Kaiser Permanente, health system owned health plans and new entrants into the marketplace, and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. Our largest competitor in our Medicare products is Original Medicare. Additional competitors in our businesses include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of

their members), third-party administrators, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefit plans, provider-owned health plans, new joint ventures, technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. In particular geographies, competitors may have greater capabilities, resources or membership; a more established reputation; superior supplier or health care professional arrangements; better business relationships; or other factors that give such competitors a competitive advantage. We compete for sales on Insurance Exchanges and are developing and expanding our Consumer Health and Services product line, where we face additional risks from existing and new competitors (including our vendors) who have lower cost structures, greater experience marketing to consumers and/or who target the higher margin portions of our business. Among our international and HIT competitors, many have longer operating histories, better brand recognition and greater market presence in many of the areas in which we are seeking to expand and more experience at rapidly innovating products. If we do not compete effectively in the geographies and product areas in which we operate, our business, operating results, financial position and cash flows could be materially and adversely affected.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our operating results and competitiveness will be adversely affected.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and healthcare utilization patterns, turnover in our membership, government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs such as new hepatitis C and cholesterol treatments and auto-immune therapies), direct-to-consumer marketing by pharmaceutical companies, the increasing influence of social media on our members' utilization and other behavior, changes in health care practices and inflation. In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers, have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, changes in health care practices, general economic conditions (such as inflation and employment levels), new technologies, clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Our operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or may make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs.

Our revenues from government-funded health and other programs, including our Medicare, Medicaid and dual eligible businesses and our government customers in our Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

For example, while the ACA provided substantial federal funding for the expansion of the number of people who qualify to enroll in Medicaid beginning in 2014, that funding is decreasing beginning in 2017, and the future of that funding is uncertain. As a result, in 2017, states are preparing for the adverse impact on their budgets and programs of expected changes to the ACA and other federal programs by seeking to reduce their Medicaid expenditures by raising minimum MLR thresholds, instituting profit caps and/or changing the design of their Medicaid programs. These changes could have a material adverse effect on the

revenues, medical benefit ratio and operating results of our Medicaid contracts and/or our ability to grow our Medicaid membership, revenues and operating results.

Our government customers also determine the eligibility criteria, premium levels and other aspects of Medicare, Medicaid and dual eligible programs that affect the number of persons enrolled in these programs, the services provided to enrollees under the programs, and our administrative and health care and other benefit costs under these programs. In the past, determinations of this type have at times adversely affected our operating results from and willingness to participate in such programs, and they may do so again in the future. For example, effective January 1, 2015, we terminated our Insured Medicaid contract in Delaware because we did not believe the premium level was adequate. If a government customer reduces premium levels or increases premiums by less than the increase in our costs (such as by not allowing us to recover ACA and other applicable fees, taxes and assessments), and we cannot offset the impact of these actions with supplemental premiums and/or changes in benefit plans, then our business and operating results could be adversely affected. In addition, if states allow certain programs to expire, reduce the number of firms with which they contract for Medicaid managed care services or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment or reduced Medicaid enrollment growth, which would adversely affect our business, revenues and operating results.

In addition, the terms of our disability products often provide that the benefits due to beneficiaries are reduced by the amount of certain federal benefits they receive, most notably SSDI payments. If such payments are suspended or reduced for any reason, including due to funding shortfalls for the SSDI program, our disability payment obligations would be increased accordingly, and such increase could be material.

Unanticipated increases in our Public Exchange and other individual Commercial product and our ACA compliant small group Commercial product health care benefit costs adversely affected our 2016 operating results and could adversely affect our operating results in 2017 and future years. Our individual Commercial products, including our Public Exchange products, were not profitable in 2016. There can be no assurance that our pricing or other actions will improve the profitability of our individual Commercial products, including our Public Exchange products, or our ACA compliant small group Commercial products in 2017. There can be no assurance that the future health care benefit costs of our individual Commercial products will not exceed our projections.

Unanticipated increases in our Public Exchange and other individual Commercial product and our ACA compliant small group Commercial product health care benefit costs adversely affected our 2016 operating results and could adversely affect our operating results in 2017 and future years. Our individual Commercial products, including our Public Exchange products, were not profitable in 2014, 2015 or 2016 due to higher than projected health care benefit costs. In 2016, we reported pretax losses of $450 million in our individual Commercial products. We project a reduced level of losses in those products in 2017.

We have set 2017 premium rates for our individual Commercial products, including our Public Exchange products, and our ACA compliant small group Commercial products based on our projections, including as to the health status and quantity of individual and small group Commercial product membership and utilization of medical and/or other covered services by individual and small group Commercial product members. The ACA’s risk management programs will provide us with less protection in 2017 than 2016. The 2017 marketplace for individual Commercial products also may be less stable than in 2016 because, among other things, other health plans have changed or stopped offering their Public Exchange products in the states we are serving in 2017, which, among other things, increases our adverse selection risk. There can be no assurance that our pricing or other actions will improve the profitability of our individual Commercial products, including our Public Exchange products, or our ACA compliant small group Commercial products in 2017 or any future year.

The premium rates for our individual Commercial and ACA compliant small group Commercial products are set in advance and fixed for one-year periods. As a result, health care benefit costs in excess of the projections reflected in our pricing for those products cannot be recovered in the fixed premium period through higher premiums. The profitability of individual Commercial and ACA compliant small group Commercial products is particularly sensitive to the accuracy of our forecasts of health care benefit costs. Those forecasts were made several months before the fixed premium period began, require a significant degree of judgment and are dependent on our ability to detect medical cost trends as well as the accuracy of our projections used in setting our individual Commercial and ACA compliant small group Commercial product premium rates.

There can be no assurance regarding the accuracy of the health care benefit cost, membership or other projections reflected in our individual Commercial and ACA compliant small group Commercial product pricing. The risks related to the accuracy of projections reflected in our pricing are magnified by adverse selection among individuals who require or utilize more expensive medical and/or other covered services (such as those who purchase coverage during special election periods), other plans' withdrawals from participation in the Insurance Exchanges we serve and legislation, regulations, enforcement activity and/or judicial decisions that cause Insurance Exchanges or Insurance Exchange products to operate in a manner different than what

we projected in setting our Insurance Exchange product premium rates, such as ongoing initiatives in several states to require insurers to allow members to pay insurers less for certain high cost drugs than the amounts assumed in pricing of their Public Exchange products or situations where ACA co-op insolvencies have required and may in the future require us to take on Public Exchange membership that we did not anticipate or price for. In addition, the limited payments under the ACA's risk corridor program for the 2014 and 2015 program years created additional instability in the marketplace for individual Commercial products in 2016 and going forward by contributing to decisions by health plans to change or stop offering their Public Exchange products. 2016 was the last year for the ACA's rick corridor program. On-going uncertainty regarding the funding of ACA-related programs and subsidies can be expected to create additional instability in the marketplace. For additional information on certain of the medical cost trend, pricing and economic conditions risks associated with our Insurance Exchange and other Health Care products, see "We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our operating results. We may not able to obtain appropriate pricing on new or renewal business" on page 27; and "We may not be able to obtain adequate premium rate increases, which would have an adverse effect on our revenues, medical benefit ratios and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes" on page 19.

The reserves we hold for expected claims are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the ACA's, CMS's and OPM's minimum MLR rules and the amounts payable by us to, and receivable by us from, the U.S. federal government under the ACA's premium stabilization programs.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within health care costs. For example, in the second and third quarters of 2016, we recorded premium deficiency reserves totaling $85 million related to anticipated future losses for the 2016 coverage year in our individual Commercial products. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable at December 31, 2016 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any negative impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, such as Public Exchanges, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization

and/or medical cost trends.

Refer to “Critical Accounting Estimates - Health Care Costs Payable” of MD&A included in Part II, Item 7 of this Annual Report on Form10-K for more information.

Our medical membership remains concentrated in certain geographic areas and industries, exposing us to unfavorable changes in local benefit costs, reimbursement rates, competition and economic conditions.

Our medical membership remains concentrated in certain geographic areas in the United States and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our operating results. Our membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our membership geographically, by product type

or by customer industry, and our revenue and operating results may be disproportionately affected by adverse changes affecting our customers.

A change in our health care product mix may impact our profit margins.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services contract products. Individuals and small employer groups are more likely to purchase our higher-risk health care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government-sponsored programs also involve our higher-risk health care products and have lower profit margins than our Insured Commercial products, and our membership is projected to continue to shift towards higher revenue, higher MBR Government products in 2017. In 2014, 2015 and 2016, our individual Commercial products, including those sold on the Public Exchanges, were not profitable. In 2016, we reported pretax losses of $450 million in our individual Commercial products. We project a reduced level of losses in those products in 2017. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our operating results.

Bids for Government business in our Health Care segment are increasingly subject to challenge, which may adversely affect contracts initially awarded to us and may result in increased costs.

We continue to increase our focus on the government customers in our Health Care segment as part of our business growth and diversification strategy. We are seeking to substantially grow our Medicare, Medicaid and dual eligibles business over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders. For example, as of January 2017, certain of our winning Medicaid bids are being protested, and during 2016 we were not successful in retaining certain Medicaid contracts. As a result, we are seeking to improve our process for responding to Medicaid requests for proposal. Our ability to maintain and grow membership, revenues and operating results in our Medicaid products is dependent on our remaining competitive on price, performance and preparing successful bids. In cases where our bid is successful, we incur defense costs and may incur unreimbursed implementation and other costs to meet contractual deadlines even if we ultimately lose the challenge.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health), life insurance and disability costs and impact our business continuity. We cannot predict whether or when any such events will occur.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the U.S. economy in general, our industry and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health), life insurance and disability costs, which would also be affected by the government's actions and the responsiveness of public health agencies and other insurers. In addition, our life insurance members and our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our business, cash flows, and operating results, and, in the event of extreme circumstances, our financial position or viability.

Our business could also be adversely affected if we do not maintain adequate procedures for crisis management, disaster recovery and business continuity during and after such events. Other than obtaining insurance coverage for our facilities and limited reinsurance of our Health Care and/or Group Insurance liabilities, there are few, if any, commercial options through which to transfer the exposure from terrorism or other extreme events away from us.

Risks Related to Our Operations

Unless we are able to develop alternative sources of revenue and earnings and achieve transformational change in our business model, our ability to profitably grow our business could be adversely affected.

We operate in a highly competitive environment and in an industry that is subject to significant ongoing changes from marketplace pressures brought about by public policy forces, the ACA, changes to or repeal or replacement of the ACA, Insurance Exchanges, customer demands, demographic shifts, new and expanding health care capabilities, business consolidations, strategic alliances, new market entrants, legislative and regulatory changes and marketing practices. As a result of these and other factors, our ability to grow profitably through the sale of traditional Insured health care and related benefits products in the United States may be limited. In order to profitably grow our business in the future, we need to diversify the sources of our revenue and earnings and transform our business model, including through developing and expanding our

Consumer Health and Services product line, making investments in consumer engagement capabilities and our Consumer Health and Services' technology and other services for health systems and provider organizations (including joint ventures, ACOs and collaborative provider networks), optimizing our business platforms and expanding internationally.

Achieving these goals will require us to devote significant senior management and other resources to acquisitions or other transactions and to develop internally or acquire new products, solutions and technology before any significant revenues or earnings are generated from such initiatives. If we are not able to acquire and/or develop and launch new products and solutions, our ability to profitably grow our business could be adversely affected.

We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted virus infections, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, malware or injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or operating results through December 31, 2016, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our Consumer Health and Services product line, including through our growth of ACS, Medicity, and ActiveHealth, increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, ACO, joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers or other third-parties, could expose our customers' private information and our customers to 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, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our business, brand, reputation, cash flows and operating results.

We may not be able to effectively manage our general and administrative expenses to competitive levels, which may reduce our membership or profitability, or we may need to implement expense reduction measures that adversely affect our future growth potential.

Our operating results depend in part on our ability to manage our general and administrative expenses to competitive levels while delivering improved customer, member and provider service, expanding our marketplace presence and accomplishing our strategic initiatives, including developing, operating and expanding our Consumer Health and

Services product line. Controlling general and administrative expenses is particularly important in our Health Care businesses that are subject to regulatory changes that may restrict our underwriting margins (calculated as premiums less health care costs), such as minimum MLR requirements. We have significant fixed costs, and our ability to reduce variable costs in the short term is limited. We attempt to manage general and administrative expenses by, among other things, making our processes more efficient, reducing the number of products we offer and controlling costs for salaries and related benefits, information technology and other general and administrative costs. However, we may not be successful in achieving the intended benefits of the cost-cutting and process improvement initiatives we undertake. In addition, our cost-cutting measures may adversely affect our ability to implement the ACA, changes to the ACA and other regulatory requirements, attract and retain key employees, maintain robust management practices and controls (including internal controls over financial reporting), implement improvements in technology and achieve our strategic goals, including profitable membership growth. Given the foregoing, we can provide no assurance that we will be able to manage our general and administrative expenses to competitive levels, which may reduce our membership, profitability and operating results and adversely affect our business and future growth potential.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, members and vendors, including our PBM services suppliers, in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the Consumer Health and Services products we are developing and seeking to expand and/or to meet current and developing industry and regulatory standards, including with regard to minimum MLR rebates, Insurance Exchanges, and various aspects of the ACA, and to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

Our business strategy involves providing customers with differentiated, easy to use, secure products and solutions that use information to meet customer needs. The types of technology and levels of service that are acceptable to customers and members today will not necessarily be acceptable in the future, requiring us to anticipate and meet marketplace demands for technology. Our success therefore is dependent in large part on our ability, within the context of a limited budget of human resources and capital and our existing and future business relationships, to timely secure, integrate, develop, redesign and enhance our (or contract with vendors to provide) technology systems that support our business strategy initiatives and processes in a compliant, secure, and cost and resource efficient manner. Integration of our acquisitions increases these challenges, and we may not be successful in integrating various systems in a timely or cost-effective manner.

Information technology projects are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care cost and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of providers, employer plan sponsors and members, developing and expanding our Consumer Health and Services product line or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

In order to remain competitive, we must further integrate our businesses, processes and systems. Pursuing multiple initiatives simultaneously could make this integration significantly more challenging.

Many of our businesses, processes and systems, both those we have acquired or will acquire, and those we have developed or are developing, are not integrated, are complex or require disproportionate resources in order to work together effectively. Businesses, processes and systems that are excessively complex or are not effectively integrated may adversely affect our ability to compete by, among other things, increasing our costs relative to competitors, reducing our flexibility and limiting our ability to react quickly to marketplace opportunities or changing circumstances. Accordingly, we must effectively and efficiently simplify and integrate these businesses, processes and systems to meet changing consumer and vendor needs and improve our productivity. This task is significantly more

difficult when we pursue multiple transactions or other initiatives, such as significant acquisitions, strategic alliances, joint ventures and multi-year strategic projects (including developing, operating and seeking to expand our Consumer Health and Services product line and implementing new provider support programs), simultaneously. Our existing business partnership relationships and a limited budget of human resources and capital present further challenges.

If we are unable to successfully simplify and integrate our businesses, processes and systems, including those from acquisitions, to realize anticipated economic and other benefits in a timely manner, it could result in substantial costs or delays and adversely affect our business, operations and operating results.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop and seek to expand our Consumer Health and Services product line and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with health plan members in these areas.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We face a wide range of risks, and our success depends on our ability to identify, prioritize and appropriately manage our enterprise risk exposures.

As a large company operating in a complex industry and in many countries, we encounter a variety of risks. The risks we face include, among other matters, the range of industry, competitive, regulatory, financial, operational or external risks identified in this "Risk Factors" discussion. We continue to devote resources to further develop and integrate our enterprise-wide risk management processes. Failure to identify, prioritize and appropriately manage or mitigate these risks, including risk concentrations across different business lines, products (e.g., Insured vs. ASC), industries, customers and geographies, can adversely affect our operating results, our ability to retain or grow business, or, in the event of extreme circumstances, our financial position or business operations.

We also face other risks that could adversely affect our business, operating results or financial position, which include:

- Health care benefits fraud by providers and members that is not prevented or detected and impacts our medical cost trends or the medical expenses of our self-insured customers. In addition, in an adverse and/or uncertain economic environment, whether in the United States or abroad, our businesses may see increased fraudulent claims volume, which may lead to additional costs because of an increase in disputed claims and litigation;
- Assessments under guaranty fund laws for obligations of insolvent insurance companies (including Penn Treaty Network America Insurance Company and one of its subsidiaries as described in Note 17 "Commitments and Contingencies - Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools" included in Part II, Item 8 of this Annual Report on Form 10-K), HMOs, ACA co ops and other payors to policyholders and claimants;
- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;

- Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our operating results and/or a deterioration in the soundness and accuracy of our reported operating results;
- Financial loss from inadequate insurance coverage due to self-insurance levels or unavailability of insurance and reinsurance coverage for credit or other reasons;
- Failure to protect our proprietary information, including as a result of cyber-attacks on us, one or more providers and/or one or more of our vendors; and
- Failure to adequately manage our run-off businesses and/or our financial exposure to businesses we have sold.

Risks Related to Customer Perceptions of our Products and Services

In order to be competitive in the growing marketplace for direct-to-consumer sales and on public and private health insurance exchanges, we will need to develop our Consumer Health and Services products and make investments in consumer engagement, reduce our cost structure and face new competitors. If we are unsuccessful, our future growth and profitability may be adversely affected.

Historically, employers have been our most significant customers. Our direct-to-consumer sales have been limited, and our individual Health Care business has been small relative to the other businesses in our Health Care segment. We are developing and seeking to expand our Consumer Health and Services product line, and we are now competing for sales on Insurance Exchanges. To develop and expand our Consumer Health and Services product line and compete effectively on Insurance Exchanges, we will be required to develop or acquire the technology systems and tools and talent necessary to interact with Insurance Exchanges and engage individual consumers using Insurance Exchanges and social media, increase our focus on individual consumers and expand and improve our consumer-focused sales and marketing channels, customer interfaces, customer service and product offerings.

We also will have to respond to pricing and other actions taken by existing competitors and regulators as well as potentially disruptive new entrants which could reduce our profit margins. Due to the price transparency provided by Insurance Exchanges, when we market our individual and small group health insurance products we face competitive pressures from existing and new competitors (including our vendors) who have lower cost structures. Our competitors may bring their Insurance Exchange and other consumer products to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our business. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of Private Exchanges or encourage their employees to purchase health insurance on the Public Exchanges. We can provide no assurance that we will be able to develop or operate successful or profitable Consumer Health and Services products or compete successfully or profitably on Public Exchanges or Private Exchanges or that we will be able to benefit from any opportunities presented by Public Exchanges or Private Exchanges. If we do not develop and expand competitive and profitable Consumer Health and Services products, are not competitive on Insurance Exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely affected.

We may not be able to compete effectively in the HIT business and earn a profit. Our HIT business increases our risk of patent infringement and other intellectual property litigation and may become subject to significant regulation in the future.

With our current focus on consumer engagement, joint ventures, ACOs, collaborative provider networks and optimizing our business platforms and our 2014 acquisition of bswift, we have increased our commitment to HIT products and solutions, a business that is rapidly changing and highly competitive. There is no assurance that we will be able to successfully adapt to changes to the HIT marketplace, or compete effectively and earn a profit in our HIT business. Our technology products and solutions may not operate as intended. Moreover, we may not have identified and mitigated, or be able to identify and mitigate, the significant risks of pursuing the HIT business, including the risk that we will be unable to protect our proprietary rights and the risks of patent infringement and other intellectual property litigation against us. Certain of our HIT products and/or solutions are subject to patent litigation, which is often associated with significant litigations costs, damages and/or injunctions.

In addition, although the HIT industry is not currently subject to significant regulation, we face an uncertain and rapidly evolving federal, state and international legislative and regulatory framework, and certain of our HIT products and/or solutions could become subject to regulation. New legislation and/or regulations may make it difficult to achieve and maintain compliance and could adversely affect both our ability to compete in the HIT business and the

operating results of our HIT business.

If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow profitable membership may be adversely affected.

We operate in a rapidly evolving industry. Our customers generally, and our larger customers in particular, are well-informed and organized and, along with our individual customers, can easily move between us and our competitors. These factors require us to differentiate our products and solutions, anticipate changes in customer and consumer preferences, anticipate and effectively compete with the products and solutions of new and existing competitors and innovate and deliver new and existing products and solutions that demonstrate value to our customers and members, particularly in response to marketplace changes from public policy. Differentiating our Insurance Exchange products is particularly challenging due to the standardization (for

example, network adequacy and standardization of benefits requirements) of these products. Any failure to do so may adversely affect our ability to retain or grow profitable membership, which can adversely affect our operating results.

If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership will be adversely affected.

Our ability to attract and retain membership is dependent upon providing cost effective, quality customer service operations (such as call center operations, claim processing, outsourced PBM functions, mail order pharmacy prescription delivery, specialty pharmacy prescription delivery, customer case installation and on-line access and tools) that meet or exceed our customers' and members' expectations. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customer and other service and performance. If we misjudge the effects of such measures, customer and other service may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. For example, CaremarkPCS Health, L.L.C. (and its predecessors, collectively, "CVS") and Express Scripts provide us with certain PBM services. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or growing profitable membership, which can adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving one of our third party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

Our competitive position and ability to differentiate our products will be adversely affected if we cannot demonstrate that our products and processes result in our members receiving quality affordable care.

One of the key factors on which we compete for customers is the degree to which our products and processes (including our disease management and patient safety programs and our provider credentialing and other quality of care and information management initiatives) result in our members receiving quality affordable care from providers, our vendors (including our PBM services suppliers) and us. If our products and process do not result in our members receiving quality affordable care, or if we are unable to demonstrate that our members receive quality affordable care, then our competitive position and ability to differentiate our product and/or solution offerings from those of our competitors would be adversely affected, which in turn could adversely affect our operating results.

Risks Related to Our Relationships with Providers, Suppliers and Vendors

If we are unable to enter into joint ventures and other collaborative risk-sharing agreements with health care providers on satisfactory terms, it may have an adverse effect on our ability to enhance our provider networks, contain our medical costs, grow our business and/or develop alternative sources of revenue and earnings.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with health care providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our ACS and ACO strategies may not achieve the intended results, which could adversely affect our operating results and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint venture. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other provider and health systems continue to consolidate across the industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain locations. These health systems are also increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our business and operating results.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

Our operating results are dependent in part upon our ability simultaneously to contract competitively with and develop and maintain favorable relationships with hospitals, physicians, pharmaceutical benefit management service providers, pharmaceutical manufacturers and other health care benefits providers. Our relationships with providers are affected by the rates we pay them for services rendered to our members (including financial incentives to deliver quality services in a cost-effective manner), by our business practices and processes, by our acquisitions and proposed acquisitions, and by our provider payment and other provider relations practices (including whether we include providers in the various provider network options we make available to our customers). Our relationships with providers are also affected by factors that impact those providers, but are not directly related to us, such as consolidations and strategic relationships among providers and/or among our competitors, changes in Medicare and/or Medicaid reimbursement levels to health care providers (including reductions due to the ATRA, sequestration and/or any repeal or amendment of the ACA), and increasing revenue and other financial pressures on providers, including increases in uncompensated care resulting from the any repeal or amendment of the ACA, ongoing reductions by CMS and state governments (including reductions due to recommendations of the Independent Payment Advisory Board, the ATRA, sequestration and/or any repeal or amendment of the ACA) in amounts payable to providers, particularly hospitals, for services provided to Medicare and Medicaid enrollees.

The breadth and quality of our networks of available providers and our ability to offer different provider network options are important factors when customers consider our products and services. Our customers, particularly our self-insured customers, also consider our hospital and other medical provider discounts when evaluating our products and services. For certain of our businesses, we must maintain provider networks that satisfy applicable access to care and/or network adequacy requirements. Regulators also consider the breadth and nature of our provider networks when assessing whether such networks meet network adequacy requirements which, in some cases, are becoming more stringent. For example, a 2016 CMS regulation established network adequacy requirements that apply to all Medicaid managed care plans. Our contracts with providers generally may be terminated by either party without cause on short notice.

The failure to maintain or to secure new cost-effective health care provider contracts, may result in a loss of or inability to grow membership, higher health care or other benefits costs (which we may not be able to reflect in our pricing due to rate reviews or other factors), health care provider network disruptions, less desirable products for our customers and/or difficulty in meeting regulatory or accreditation requirements, any of which could adversely affect our operating results.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our members.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these non-participating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, since 2007, we have been in class litigation with non-participating providers over our payments to them, and during 2009, we settled a matter with the New York Attorney General that caused us to transition to different databases to determine the amount we pay non-participating providers under certain benefit plan designs. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Certain of these matters are described in more detail in “Litigation and Regulatory Proceedings” in Note 17 “Commitments and Contingencies” included in Part II, Item 8 of this Annual Report on Form 10-K.

We could become overly dependent on key service providers, which could expose us to operational risks and cause us to lose core competencies. If their services become unavailable, we may experience service disruptions, reduced service quality and increased costs and may be unable to meet our obligations to our customers.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. These third parties include our PBM services suppliers, information technology system providers, independent practice associations, accountable care organizations and call center and claim and billing service providers. Certain of these third parties provide us with significant portions of our requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. Certain third parties to whom we delegated selected functions, such as independent practice associations and specialty services providers, have experienced financial difficulties, including bankruptcy. Furthermore, certain legislative authorities have in recent years discussed or proposed legislation that would restrict outsourcing. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruption or unavailability, reduced service quality and effectiveness, increased or duplicative costs, an inability to meet our obligations to our customers or require us to seek alternative service providers on less favorable contract terms, any of which can adversely affect our business, brand, reputation and/or operating results. Furthermore, where our arrangements with these service providers are not acceptable to our customers, we must make alternate arrangements, which may be more costly and difficult to implement.

In particular, we have entered into agreements with our PBM services suppliers to provide us and certain of our customers and members with certain PBM services. If our PBM agreement with CVS or our agreements with our other PBM services supplier were to terminate for any reason or one of our PBM services supplier’s ability to perform their respective obligations under their agreements with us were impaired, we may not be able to find an alternative supplier in a timely manner or on acceptable financial terms. As a result, our costs may increase, we would not realize the anticipated benefits of our PBM agreement with CVS or our other agreements for PBM services (including projected operating efficiencies), and we may not be able to meet the full demands of our customers, any of which could have a material adverse effect on our business, brand, reputation and/or operating results.

Risks Related to Our Acquisitions and International Operations

We expect to continue to pursue acquisitions and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing business, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to integration risks, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- The acquired and/or joint venture businesses may not perform as projected;
- The goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become non-recoverable;
- We may not obtain the projected synergies as we integrate the acquired businesses;
- We may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;

We may experience difficulties in integrating acquired businesses into our existing operations (including our internal control environment), be unable to integrate acquired businesses successfully or as quickly as expected, and be unable to realize anticipated economic, operational and/or other benefits in a timely manner or at all, which could result in substantial costs and delays or other operational, technical or financial problems;

- The acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;

- We may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our shareholders;
- We may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- We may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of companies we acquire, which may be difficult or impossible to accomplish;
- We may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, material disruptions to our business and operations and negatively affect our brand and reputation;
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business;
- We may be involved in litigation related to mergers or acquisitions, including for matters which occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- The integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

We expect joint ventures to be a critical part of our business model transformation and inorganic growth strategies. Joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, growing the joint venture's business in a manner acceptable to all the parties, maintaining positive relationships among the joint venture parties and the customer, and member and business disruption that may occur upon joint venture termination.

As we expand our international operations, we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations. Our exposure to these risks is expected to increase.

As we expand our international operations we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, privacy, data storage, location, protection and security.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the Bribery Act 2010) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and management, financial and other resources over a number of years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our business and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our business, operating results, financial position, brand, reputation and/or long-term growth.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, customs and employee relationships that can be difficult, less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business partners, which requires us to manage our partner relationships and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may have an impact on our revenues, operating results and cash flows from our international operations. Some

of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Our exposure to all of the above risks is expected to increase as we seek to grow our foreign operations over the next several years.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, business, cash flows, financial position and operating results.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by recognized rating organizations. Credit ratings issued by nationally-recognized organizations are broadly distributed and generally used throughout our industry. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our products to certain of our customers. In addition, our credit ratings impact the cost and availability of future borrowings, and accordingly our cost of capital.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Among other things, our ratings may be affected by the assumption and/or issuance of debt in connection with an acquisition. For example, following the announcement of the Humana Acquisition in July 2015, each of Standard & Poor's, A.M. Best, Fitch and Moody's placed certain of our debt, financial strength and other credit ratings under review for possible downgrade. Following the issuance of the 2016 senior notes, each of Standard & Poor's, A.M. Best and Moody's downgraded certain of our debt, financial strength and other credit ratings by one notch. Downgrades or potential downgrades in our ratings, should they occur, could adversely affect our brand and reputation, business, cash flows, financial position and operating results.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our operating results and/or our financial position.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the United States. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the United States, and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the United States credit markets, and governments' monetary policy, particularly United States monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial position by:

- Significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- Keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results as the proceeds

from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;

- Reducing the fair values of our investments if interest rates rise;
- Causing non-performance or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;

- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure to adequately do so could adversely affect our net income and our financial position and, in extreme circumstances, our cash flows.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our principal office is a building complex that is approximately 1.7 million square feet in size and is located at 151 Farmington Avenue, Hartford, Connecticut. Our principal office is used by all of our business segments. We also own or lease other space in the greater Hartford area, Bethesda, Maryland, Blue Bell, Pennsylvania, and various field locations in the U.S. and several foreign countries. Such properties are primarily used by our Health Care segment. We believe our properties are adequate and suitable for our business as presently conducted.

Item 3. Legal Proceedings

The Information contained under “Litigation and Regulatory Proceedings” in Note 17 “Commitments and Contingencies” included in Part II, Item 8 of this Annual Report on Form10-K is incorporated by reference herein.

Item 4. Mine Safety Disclosures

Not applicable.

Part II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information
Our common shares (“common stock”) are listed on the New York Stock Exchange, where they trade under the symbol AET. The following table presents high and low sales prices for our common stock for the periods indicated.

	High	Low
2016		
First quarter	$114.19	$94.31
Second quarter	122.72	107.90
Third quarter	121.04	112.81
Fourth Quarter	134.90	105.20
2015		
First quarter	$109.26	$87.60
Second quarter	132.60	106.08
Third quarter	128.90	105.30
Fourth Quarter	115.34	99.89

Holders of our Common Stock
At January 31, 2017, there were 6,467 record holders of our common stock.

Dividends
The quarterly cash dividend declared by Aetna’s Board of Directors (our “Board”) was $.25 per share in 2016 and 2015. In 2014, the quarterly cash dividend declared was $.225 for the first, second and third quarters and $.25 for the fourth quarter. On February 17, 2017, our Board declared a cash dividend of $.50 per common share that will be paid on April 28, 2017, to shareholders of record at the close of business on April 13, 2017.

Declaration and payment of future dividends is at the discretion of our Board and may be adjusted as business needs or marketplace conditions change. Information regarding restrictions on our present and future ability to pay dividends is included in “Liquidity and Capital Resources” of MD&A included in Part II, Item 7 and Note 13 “Shareholders’ Equity” included in Part II, Item 8 of this Annual Report on Form 10-K.

Securities Authorized for Issuance under Equity Compensation Plans
The information required by this Item concerning securities authorized for issuance under our equity compensation plans is incorporated herein by reference to “Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters” included in Part III, Item 12 in this Annual Report on Form 10-K.

Issuer Purchase of Equity Securities
During the three months ended December 31, 2016, we did not repurchase any shares of common stock. At December 31, 2016, we had remaining authorization to repurchase an aggregate of up to approximately $1.1 billion of common stock under our November 21, 2014 and February 28, 2014 programs. On February 17, 2017, our Board approved a new share repurchase program that authorized us to repurchase up to $4.0 billion of our common stock.

Prior to the termination of the Humana Merger Agreement, our ability to repurchase shares of our common stock was limited.

Refer to Note 13 “Shareholders’ Equity” included in Part II, Item 8 of this Annual Report on Form 10-K for information regarding our share repurchases including Board authorizations, shares repurchased during 2016 and our remaining

share repurchase authorization as of December 31, 2016.

Corporate Performance Graph

The following graph compares the cumulative total shareholder return on our common stock (assuming reinvestment of dividends) with the cumulative total return on the published Standard & Poor's 500 Stock Index ("S&P 500") and the cumulative total return on the published Standard & Poor's Supercomposite Managed Health Care Index ("S&P MHCI") from December 31, 2011 through December 31, 2016. The graph assumes a $100 investment in shares of our common stock on December 31, 2011.

	December 31,					
	2011	2012	2013	2014	2015	2016
AET	$100	$112	$168	$220	$270	$312
S&P	100	116	154	175	177	198
S&P MHCI [(1)]	100	106	156	210	255	304

(1) At December 31, 2016, the companies included in the S&P MHCI were: Aetna Inc., Anthem, Inc., Centene Corporation, Cigna Corporation, HealthEquity, Inc., Humana Inc., Magellan Health, Inc., Molina Healthcare, Inc., UnitedHealth Group Incorporated and WellCare Health Plans, Inc.

Shareholder returns over the period shown on the corporate performance graph should not be considered indicative of future shareholder returns.

Item 6. Selected Financial Data

The table below provides selected consolidated financial data of Aetna. The information has been derived from our consolidated financial statements for each of the years in the five year period ended December 31, 2016. You should read this selected consolidated financial data in conjunction with MD&A included in Part II, Item 7 of this Annual Report on Form 10-K and the audited consolidated financial statements and notes as of and for the year ended December 31, 2016 included in Part II, Item 8 of this Annual Report on Form 10-K.

	As of and for the Years Ended December 31,				
(Millions, except per common share data)	2016	2015	2014	2013 [1]	2012[1]
Income Statement Data					
Total revenue	$63,155	$60,337	$58,003	$47,295	$36,600
Net income attributable to Aetna	2,271	2,390	2,041	1,914	1,658
Net realized capital gains (losses), net of tax	56	(42)	52	(7)	71
Per Common Share Data					
Cumulative annual dividends declared	$1.00	$1.00	$.925	$.825	$.725
Net income attributable to Aetna:					
Basic	6.46	6.84	5.74	5.38	4.87
Diluted	6.41	6.78	5.68	5.33	4.81
Balance Sheet Data					
Total assets [2]	$69,146	$53,509	$53,354	$49,723	$41,341
Short-term debt	—	—	500	—	—
Long-term debt [2]	20,661	7,785	8,033	8,210	6,435
Total Aetna shareholders' equity	17,881	16,114	14,483	14,026	10,406

[1] We acquired Coventry Health Care, Inc. ("Coventry") in May 2013, which impacts the comparability of operating results for the years ended December 31, 2013 to 2016 to prior periods.

[2] Amounts as of December 31, 2012 to 2015 have been retroactively restated to reflect the reclassification of debt issuance costs from other current and long-term assets to a reduction of long-term debt as a result of the adoption of new accounting guidance during the year ended December 31, 2016.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations (“MD&A”)

OVERVIEW

We are one of the nation’s leading diversified health care benefits companies, serving an estimated 46.7 million people. We have the information and resources to help our members, in consultation with their health care professionals, make better informed decisions about their health care. We offer a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, medical management capabilities, Medicaid health care management services, Medicare Advantage and Medicare Supplement plans, workers’ compensation administrative services and health information technology (“HIT”) products and services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers (“providers”), governmental units, government-sponsored plans, labor groups and expatriates. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions.

The following MD&A provides a review of our financial condition at December 31, 2016 and December 31, 2015 and operating results for the years ended December 31, 2016, 2015 and 2014. This Overview should be read in conjunction with the entire MD&A, which contains detailed information that is important to understanding our operating results and financial condition, the consolidated financial statements and other data presented in this Annual Report on Form 10-K. This Overview is qualified in its entirety by the full MD&A.

Summarized Results

				Change 2016 vs. 2015		2015 vs. 2014	
(Millions, except total medical membership)	2016	2015	2014	$	%	$	%
Total revenue	$63,155	$60,337	$58,003	$2,818	5 %	$2,334	4 %
Net income attributable to Aetna	2,271	2,390	2,041	(119)	(5)%	349	17 %
Operating earnings [1]	2,917	2,717	2,405	200	7 %	312	13 %
Total medical membership (in thousands)	23,110	23,487	23,548	(377)	(2)%	(61)	— %
Cash flows from operations	3,719	3,866	3,373	(147)	(4)%	493	15 %

(1) Operating earnings excludes from net income attributable to Aetna net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K.

Our discussion of operating results for our reportable business segments is based on operating earnings, which is a non-GAAP measure of net income attributable to Aetna (the term “GAAP” refers to U.S. generally accepted accounting principles). Non-GAAP financial measures we disclose, such as operating earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. Refer to “Segment Results and Use of Non-GAAP Measures in this Document” below in this MD&A for a discussion of non-GAAP measures. Refer to Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K for a reconciliation of net income attributable to Aetna to operating earnings.

Commentary - 2016 compared to 2015

- Net income attributable to Aetna decreased $119 million in 2016 compared to 2015 primarily due to an increase in restructuring costs which include a $215 million ($330 million pre-tax) expense recorded during 2016 related to our previously announced voluntary early retirement program, higher transaction and integration-related costs and the favorable impact of litigation-related proceeds recorded during 2015. The decrease was partially offset by the increase in operating earnings described below, net realized capital gains during 2016 compared with net realized capital losses

during 2015 and the favorable impact of the 2016 reduction of our reserve for anticipated future losses on discontinued products.

- Operating earnings increased $200 million in 2016 compared to 2015, primarily as a result of higher fees and other revenue in our Health Care segment.
- Total revenue increased approximately $2.8 billion during 2016 compared to 2015, primarily due to to higher premiums in our Health Care segment.

- Total medical membership at December 31, 2016 decreased 377 thousand members compared to December 31, 2015, primarily reflecting declines in our Commercial business, partially offset by growth in our Government business. Refer to "Health Care - Membership" below in this MD&A for further information.

Commentary - 2015 compared to 2014

- Net income attributable to Aetna increased $349 million in 2015 compared to 2014 primarily due to the increase in operating earnings described below and the loss on early extinguishment of long-term debt recorded in 2014, partially offset by net realized capital losses in 2015 compared with net realized capital gains in 2014.
- Operating earnings increased $312 million in 2015 compared to 2014 primarily as a result of higher underwriting margins (calculated as premiums less health care costs) and higher fees and other revenue in our Health Care segment, partially offset by an increase in general and administrative expenses.
- Total revenue increased $2.3 billion in 2015 compared to 2014 primarily due to membership growth in our Government business as well as higher Health Care premium yields, partially offset by membership losses in our group Commercial Insured products.
- Total medical membership at December 31, 2015 remained relatively flat compared to December 31, 2014, primarily reflecting declines in our Commercial Insured products substantially offset by growth in our Medicare and Medicaid products. Refer to "Health Care - Membership" below in this MD&A for further information.

During the past three years our cash flows supported both new and ongoing initiatives.

We generated substantial cash flows in the past three years, which we used to support our ordinary course operating activities; increase cash and cash equivalents in preparation for our then proposed acquisition of Humana Inc. (the "Humana Acquisition"); repurchase our common stock; repurchase our long-term debt; and pay shareholder dividends. During 2016, we issued $13 billion of senior notes to partially fund the Humana Acquisition. We did not repurchase any shares of our common stock in 2016. During 2015 and 2014, we repurchased 3 million and 16 million shares of our common stock, respectively, at a cost of $296 million and approximately $1.2 billion, respectively, under share repurchase programs authorized by our Board. Prior to the termination of the Merger Agreement (as defined below), our ability to repurchase shares of our common stock was limited. Refer to Note 13 "Shareholders' Equity" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on share repurchases.

Refer to "Liquidity and Capital Resources" below in this MD&A for additional information on our primary sources and uses of cash flows.

Outlook for 2017

In August 2016, we announced that we would reduce our participation on the individual public health insurance exchanges established pursuant to the ACA ("Public Exchanges") to 242 counties for the 2017 plan year from the 778 counties we served in the 2016 plan year. We have maintained an on-Public Exchange presence for the 2017 plan year in Delaware, Iowa, Nebraska and Virginia. We have modified our off-Public Exchange product options for 2017 in the vast majority of counties where we offered individual Public Exchange products in 2016, which may adversely affect 2017 membership and premium in those counties. Based on our current view of open enrollment, we project first quarter 2017 Individual Commercial products membership will decline from approximately 965 thousand members at December 31, 2016 to approximately 240 thousand members at March 31, 2017.

We see the following opportunities in 2017:

- Projected growth in our Commercial business operating earnings, including a reduced level of losses in our Individual Commercial products;
- Projected continued Medicare top-line growth primarily due to continued strong growth in our Individual Medicare Advantage products; and
- The resumption of share repurchase activity.

In 2017, we also project the following challenges:

- The projected negative impact on operating earnings of known state Medicaid contract losses; and
- Lower projected Group Insurance segment operating earnings.

Refer to “Risk Factors” included in Part I, Item 1A of this Annual Report on Form 10-K for information regarding other important factors that may cause our actual results to differ from those currently projected and/or otherwise materially affect us.

Terminated Acquisition of Humana and Terminated Divestiture to Molina

On July 2, 2015, we entered into a definitive agreement (the "Merger Agreement") to acquire Humana Inc. ("Humana") in a transaction valued at approximately $37 billion, based on the closing price of Aetna common shares on July 2, 2015, including the assumption of Humana debt and Humana cash and cash equivalents.

On July 21, 2016, the U.S. Department of Justice (the "DOJ") and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that the Humana Acquisition would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Acquisition. On February 14, 2017, Aetna and Humana entered into a mutual termination agreement (the "Termination Agreement") pursuant to which the parties thereto (collectively, the "Parties") agreed to terminate the Merger Agreement, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby, entered pursuant thereto or entered in connection therewith (other than certain confidentiality agreements) (collectively with the Merger Agreement, the "Transaction Documents"), effective immediately as of February 14, 2017 (the "Termination Date"). Under the Termination Agreement, Aetna agreed to pay Humana the Regulatory Termination Fee (as defined in the Merger Agreement) of $1.0 billion in cash in full satisfaction of any amounts required to be paid by Aetna under the Merger Agreement. The Parties also agreed to release each other from any and all liability, claims, rights, actions, causes of action, suits, liens, obligations, accounts, debts, demands, agreements, promises, liabilities, controversies, costs, charges, damages, expenses and fees, however arising, in connection with, arising out of or related to the Transaction Documents, the transactions contemplated therein or thereby or certain related matters. We paid Humana the Regulatory Termination Fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes (as defined below).

In June 2016, we issued $13.0 billion of senior notes to partially fund the Humana Acquisition (collectively, the "2016 senior notes"). In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for $10.2 billion aggregate principal amount of certain of the 2016 senior notes (collectively, the "Special Mandatory Redemption Notes") at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017, and we expect to fund the redemption with the proceeds of the 2016 senior notes. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption.

In order to address the DOJ's perceived competitive concerns regarding Medicare Advantage relating to the Humana Acquisition, on August 2, 2016, we entered into a definitive agreement (the "Aetna APA") to sell for cash to Molina Healthcare, Inc. ("Molina") certain of our Medicare Advantage assets. On February 14, 2017, Aetna and Molina entered into a Termination Agreement (the "APA Termination Agreement") pursuant to which Aetna terminated the Molina APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, Aetna agreed to pay Molina in cash (a) a termination fee of $53 million and (b) approximately 70% of Molina's transaction costs. We paid Molina the termination fee on February 16, 2017 and funded that payment with the proceeds of the 2016 senior notes. We expect to pay Molina the applicable transaction costs during the first quarter of 2017.

Refer to Notes 3 "Acquisitions, Terminated Acquisition and Terminated Divestiture" and 9 "Debt" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the Humana Acquisition.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") has made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate efforts in 2017 and beyond to substantially modify, repeal or replace the ACA, we expect aspects of the ACA to continue to significantly impact our business operations and operating results, including our pricing, our MBRs and the geographies in which our products are available. The ACA has presented us with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including Public Exchanges, required minimum MLRs in Commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." The effects of these changes are reflected in our operating results. If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2020.

During the years ended December 31, 2016, 2015 and 2014, we paid the following fees and contributions required by the ACA:

(Millions)	2016	2015	2014
Current year HIF	$837	$856	$605
Estimated current year ACA reinsurance contribution	114	185	298
Remaining portion of prior year ACA reinsurance contribution	62	60	—

In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the ACA's health insurer fee (the "HIF").

Ongoing legislative and regulatory changes to the ACA, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of the ACA (including risk corridors), the results of the 2016 presidential, congressional and state level elections, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Examples of recent legislative and regulatory changes include: the January 20, 2017 executive order relating to the ACA; the November 2016 HHS announcement that risk corridor collections for the 2015 program year will be applied first to amounts owed to plans for the 2014 program year; the May 2016 final regulations relating to the ACA's non-discrimination requirements; the December 2015 suspension of the HIF for 2017 and two year delay of the "Cadillac" tax on high-cost employer-sponsored health coverage; the October 2015 PACE, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that the ACA's risk corridor receivables for the 2014 program year would only be funded at 12.6%. With respect to pending litigation, in May 2016, the U.S. District Court for the District of Columbia ruled that the U.S. Department of Health and Human Services does not have the authority to make payments under the ACA's Cost Sharing Subsidy program. Implementation of this decision has been stayed pending appeal.

As described above, the availability of funding for the ACA's temporary risk corridor program is an example of this uncertainty. We continue to believe that receipt of any risk corridor payment from HHS for the 2016 or 2015 program year and receipt of such payments in excess of the announced prorated amount for the 2014 program year are uncertain. At December 31, 2016, we had an immaterial receivable for the remaining 2014 program year prorated

amount that had not been collected from HHS and no receivable for either of the 2015 or 2016 program years. In addition, these limited risk corridor payments created additional instability in the marketplace for individual Commercial products in 2016 and going forward by contributing to decisions by health plans to change or stop offering their Public Exchange products. 2016 was the last program year for the ACA's risk corridor program. On-going uncertainty regarding the funding of ACA-related programs and subsidies can be expected to create additional instability in the marketplace.

The federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system. We cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or the ACA or the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

For additional information on the ACA, refer to "Regulatory Environment" below in this MD&A and Notes 2 "Summary of Significant Accounting Policies" and 8 "The ACA's Reinsurance, Risk Adjustment and Risk Corridor" included in Part II, Item 8 of this Annual Report on Form 10-K. For a discussion of certain factors that may cause our actual results to differ from currently anticipated results in connection with the ACA, refer to "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K.

Medicare Update

On April 5, 2016, CMS issued its final notice detailing final 2017 Medicare Advantage benchmark payment rates (the "Final Notice"). The Final Notice provides for rate cuts to the employer group waiver program that will begin in 2017 and be fully phased in for 2018 as well as adverse changes to the risk adjustment mechanism for dual eligible beneficiaries and the Medicare Advantage star rating program. Overall, we project the benchmark rates in the Final Notice will decrease funding for our Medicare Advantage business by less than 1 percent in 2017 compared to 2016.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released our 2017 star ratings in October 2016. Our 2017 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2018. Based on our membership at December 31, 2016, 92% of our Medicare Advantage members were in plans with 2017 star ratings of at least 4.0 stars, compared to 85% of our Medicare Advantage members being in plans with 2016 star ratings of at least 4.0 stars based on our membership at December 31, 2015. During 2016, our star ratings resulted in additional revenue of approximately $560 million, inclusive of bonus payments and rebates.

Voluntary Early Retirement Program

In September 2016, we announced a voluntary early retirement program (the "Program"). Under the terms of the Program, eligible employees elected early retirement during the fourth quarter of 2016. In connection with the Program, we recorded an expense of $330 million pretax for the year ended December 31, 2016.

Management Update

Thomas J. Sabatino, Jr., Executive Vice President and General Counsel, joined Aetna in April 2016 and succeeded William J. Casazza who decided to retire and agreed to continue to serve as a strategic advisor to Aetna in connection with the Humana Acquisition until March 2017.

Segment Results and Use of Non-GAAP Measures in this Document

The following discussion of operating results is presented based on our reportable segments in accordance with the accounting guidance for segment reporting and is consistent with our segment disclosure included in Note 18 "Segment Information" included in Part II, Item 8 of this Annual Report on Form 10-K. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments to reconcile our segment reporting to our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and the financing components of our pension and other postretirement employee benefit plans ("OPEB") expense (the service cost and prior service cost components of this expense are allocated to our business segments).

Operating earnings discussed in this Annual Report on Form 10-K exclude from net income attributable to Aetna reported in accordance with GAAP net realized capital gains or losses, amortization of other acquired intangible assets and other items, if any, that neither relate to the ordinary course of our business nor reflect our underlying business performance. Although the excluded items may recur, we believe excluding them from net income attributable to Aetna to arrive at operating earnings provides a more useful comparison of our underlying business performance from period to period. Net realized capital gains and losses arise from various types of transactions, primarily in the course

of managing a portfolio of assets that support the payment of liabilities. Amortization of other acquired intangible assets relates to our acquisition activities, including Coventry Health Care, Inc. (“Coventry”), the InterGlobal Group (“InterGlobal”) and bswift LLC (“bswift”). These transactions and amortization do not directly relate to the underwriting or servicing of products for our customers and are not directly related to the core performance of our business operations. Operating earnings is the measure reported to our Chief Executive Officer for purposes of assessing financial performance and making operating decisions, such as the allocation of resources among our business segments. In each business segment discussion in this MD&A, we provide a table that reconciles net income attributable to Aetna to operating earnings. Each table details the net realized capital gains or losses, amortization of other acquired intangible assets and any other items excluded from net income attributable to Aetna, and the footnotes to each table describe the nature of each other item and the reason we believe it is appropriate to exclude that item from net income

attributable to Aetna. Non-GAAP financial measures we disclose, such as operating earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

HEALTH CARE

Health Care consists of medical, pharmacy benefit management services, dental, behavioral health and vision plans offered on both an Insured basis (where we assume all or a majority of the risk for medical and dental care costs) and an employer-funded basis (where the plan sponsor under an administrative services contract ("ASC") assumes all or a majority of this risk) and emerging businesses products and services that complement and enhance our medical products. We also offer Medicare and Medicaid products and services and other medical products, such as medical management and data analytics services, medical stop loss insurance, workers' compensation administrative services and products that provide access to our provider networks in select geographies. We separately track premiums and health care costs for Government businesses (which represent our combined Medicare and Medicaid products). All other medical, dental and other Health Care products are referred to as Commercial.

Operating Summary

				Change 2016 vs. 2015		Change 2015 vs. 2014	
(Millions)	2016	2015	2014	$	%	$	%
Premiums:							
Commercial	$27,916	$28,709	$28,563	$(793)	(3)%	$146	1%
Government	26,200	22,909	20,999	3,291	14%	1,910	9%
Total premiums	54,116	51,618	49,562	2,498	5%	2,056	4%
Fees and other revenue	5,744	5,585	5,115	159	3%	470	9%
Net investment income	458	408	368	50	12%	40	11%
Net realized capital gains (losses)	52	(50)	64	102	204%	(114)	(178)%
Total revenue	60,370	57,561	55,109	2,809	5%	2,452	4%
Health care costs:							
Commercial	22,896	23,057	22,918	(161)	(1)%	139	1%
Government	21,359	18,655	17,829	2,704	14%	826	5%
Total health care costs	44,255	41,712	40,747	2,543	6%	965	2%
Operating expenses:							
Selling expenses	1,545	1,490	1,537	55	4%	(47)	(3)%
General and administrative expenses	10,099	9,766	8,801	333	3%	965	11%
Total operating expenses	11,644	11,256	10,338	388	3%	918	9%
Amortization of other acquired intangible assets	247	255	242	(8)	(3)%	13	5%
Total benefits and expenses	56,146	53,223	51,327	2,923	5%	1,896	4%
Income before income taxes	4,224	4,338	3,782	(114)	(3)%	556	15%
Income tax expense	1,856	1,908	1,587	(52)	(3)%	321	20%
Net income including non-controlling interests	2,368	2,430	2,195	(62)	(3)%	235	11%
Less: Net (loss) income attributable to non-controlling interests	(15)	3	2	(18)	(600)%	1	50%
Net income attributable to Aetna for Health Care	$2,383	$2,427	$2,193	$(44)	(2)%	$234	11%

We calculate our medical benefit ratio ("MBR") by dividing health care costs by health care premiums. Our Commercial, Government and Total Health Care MBRs for the last three years were:

	Change (basis

				points)	
	2016	2015	2014	2016 vs. 2015	2015 vs. 2014
Commercial	82.0 %	80.3 %	80.2 %	170	10
Government	81.5 %	81.4 %	84.9 %	10	(350)
Total Health Care	81.8 %	80.8 %	82.2 %	100	(140)

The table presented below reconciles net income attributable to Aetna to operating earnings [1] for our Health Care segment:

(Millions)	2016	2015	2014
Net income attributable to Aetna for Health Care	$2,383	$2,427	$2,193
Transaction and integration-related costs	230	208	201
Restructuring costs	404	15	—
Release of litigation-related reserve	—	—	(103)
Litigation-related proceeds	—	(110)	—
Amortization of other acquired intangible assets	247	255	242
Net realized capital (gains) losses	(52)	50	(64)
Income tax benefit	(264)	(133)	(92)
Operating earnings for Health Care	$2,948	$2,712	$2,377

(1) Operating earnings excludes net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2016 compared to 2015

- Net income attributable to Aetna for Health Care decreased $44 million in 2016 compared to 2015, primarily as a result of an increase in restructuring costs and the favorable impact of litigation-related proceeds recorded during 2015, substantially offset by the increase in operating earnings described below and net realized capital gains during 2016 compared with net realized capital losses during 2015.
- Operating earnings increased by $236 million in 2016 compared to 2015, primarily as a result of higher underwriting margins in our Government business, higher fees and other revenue primarily due to higher average fee yields, and lower general and administrative expenses. The increase was partially offset by lower underwriting margins in Aetna's Commercial business.
- Commercial premiums were $793 million lower in 2016 than 2015, primarily as a result of membership losses in our Commercial Insured products, partially offset by higher premium yields.
- Our Commercial MBR increased 170 basis points over the prior year. The increase in our Commercial MBR is primarily due to higher medical costs in our Individual Commercial products and performance in our Middle Market Commercial products.
- Government premiums were approximately $3.3 billion higher in 2016 than 2015 primarily due to membership growth in our Government business.
- Our Government MBR remained consistent in 2016 compared to 2015 reflecting higher MBRs in our Medicaid products and lower favorable development of prior-year health care cost estimates in 2016, offset by improved performance in our Medicare products.
- Health Care fees and other revenue for 2016 increased $159 million compared to 2015 primarily due to higher average fee yields in 2016, partially offset by the favorable impact of $110 million pretax of net litigation-related proceeds recorded in 2015.
- General and administrative expenses increased by $333 million during 2016 compared to 2015 primarily due to an increase in restructuring costs, which include a $330 million expense recorded during 2016 related to our previously announced voluntary early retirement program.
- Our effective tax rate was 44 percent in both 2016 and 2015.

Commentary - 2015 compared to 2014

- Net income attributable to Aetna for Health Care increased by $234 million in 2015 compared to 2014, primarily as a result of the increase in operating earnings described below and the favorable impact of $110 million pretax of net litigation-related proceeds recorded in 2015, partially offset by net realized capital losses in 2015 compared with net realized capital gains in 2014, as well as 2014 net income including the favorable impact of the release of a

litigation-related reserve.

- Operating earnings increased by $335 million in 2015 compared to 2014, primarily as a result of higher underwriting margins in our Government business and higher fees and other revenue, partially offset by an increase in general and administrative expenses.

- Commercial premiums were $146 million higher in 2015 than 2014, primarily as a result of higher premium yields partially offset by membership losses in our group Commercial Insured products and an increase in net ACA risk adjustment payables recorded in 2015.
- Our Commercial MBR increased 10 basis points in 2015 compared to 2014 primarily due to performance in our ACA compliant products substantially offset by improved performance in our group Commercial products.
- Government premiums were approximately $1.9 billion higher in 2015 compared to 2014 primarily due to membership growth in both our Medicare and Medicaid Insured products.
- Our Government MBR improved 350 basis points in 2015 compared with 2014 primarily as a result of actions impacting revenue and medical costs designed to solve for the gap between Medicare premiums and medical costs and other expenses and improved performance in our Medicaid products.
- Health Care fees and other revenue for 2015 increased $470 million compared to 2014 primarily as a result of higher average fee yields, the favorable impact of $110 million pretax of net litigation-related proceeds recorded in 2015 and growth in our Commercial ASC membership.
- General and administrative expenses increased by $965 million during 2015 compared to 2014 primarily due to higher employee-related costs, increased investment spend to support our growth initiatives and 2014 operating results including the favorable impact of the release a litigation-related reserve. Refer to Note 17 “Commitments and Contingencies” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the release of the litigation-related reserve.
- Our effective tax rate was 44 percent in 2015 compared to 42 percent in 2014. The increase in 2015 compared to 2014 primarily reflects a higher 2015 non-tax deductible HIF, partially offset by lower estimated state taxes.

Membership

Health Care’s membership at December 31, 2016 and 2015 was:

	2016			2015			Change 2016 vs. 2015		
(Thousands)	Insured	ASC	Total	Insured	ASC	Total	Insured	ASC	Total
Medical:									
Commercial	5,457	13,132	18,589	5,777	13,593	19,370	(320)	(461)	(781)
Medicare Advantage	1,362	—	1,362	1,251	—	1,251	111	—	111
Medicare Supplement	685	—	685	566	—	566	119	—	119
Medicaid [1]	1,668	806	2,474	1,529	771	2,300	139	35	174
Total Medical Membership	9,172	13,938	23,110	9,123	14,364	23,487	49	(426)	(377)
Dental:									
Total Dental Membership	6,086	8,386	14,472	6,243	8,391	14,634	(157)	(5)	(162)
Pharmacy:									
Commercial			9,400			10,237			(837)
Medicare PDP (stand-alone)			2,067			1,466			601
Medicare Advantage PDP			953			863			90
Medicaid [1]			2,783			2,587			196
Total Pharmacy Benefit Management Services			15,203			15,153			50

[1] Medicaid membership includes members who are dually-eligible for both Medicare and Medicaid.

Commentary - 2016 compared to 2015

- Total medical membership at December 31, 2016 decreased 377 thousand members compared to December 31, 2015, primarily reflecting membership declines in our Commercial business, partially offset by growth in our Government business.

- Total dental membership at December 31, 2016 decreased 162 thousand members compared to December 31, 2015 primarily reflecting membership declines in our Insured dental products.

- Total pharmacy benefit management services membership remained relatively flat at December 31, 2016 compared to December 31, 2015 primarily reflecting membership growth in our Government business, substantially offset by membership declines in our Commercial business.

GROUP INSURANCE

Group Insurance primarily includes group life insurance and group disability products. Group life insurance products are offered on an Insured basis. Group disability products are offered to employers on both an Insured and an ASC basis. Group Insurance also includes long-term care products that were offered primarily on an Insured basis. We no longer solicit or accept new long-term care customers.

Operating Summary

				Change 2016 vs. 2015		2015 vs. 2014	
(Millions)	2016	2015	2014	$	%	$	%
Premiums:							
Life	$1,142	$1,216	$1,241	$(74)	(6)%	$(25)	(2)%
Disability	957	879	825	78	9 %	54	7 %
Long-term care	44	44	44	—	— %	—	— %
Total premiums	2,143	2,139	2,110	4	— %	29	1 %
Fees and other revenue	108	101	104	7	7 %	(3)	(3)%
Net investment income	226	238	261	(12)	(5)%	(23)	(9)%
Net realized capital gains	24	—	15	24	100 %	(15)	(100)%
Total revenue	2,501	2,478	2,490	23	1 %	(12)	— %
Current and future benefits	1,850	1,837	1,798	13	1 %	39	2 %
Operating expenses:							
Selling expenses	133	121	116	12	10 %	5	4 %
General and administrative expenses	353	346	337	7	2 %	9	3 %
Total operating expenses	486	467	453	19	4 %	14	3 %
Amortization of other acquired intangible assets	—	—	2	—	— %	(2)	(100)%
Total benefits and expenses	2,336	2,304	2,253	32	1 %	51	2 %
Income before income taxes	165	174	237	(9)	(5)%	(63)	(27)%
Income tax expense	26	38	57	(12)	(32)%	(19)	(33)%
Net income attributable to Aetna for Group Insurance	$139	$136	$180	$3	2 %	$(44)	(24)%

We calculate our group benefit ratio by dividing current and future benefits by total premiums. Our group benefit ratios for the last three years were:

				Change (basis points)	
	2016	2015	2014	2016 vs. 2015	2015 vs. 2014
Group benefit ratio	86.3 %	85.9 %	85.2 %	40	70

The table presented below reconciles net income attributable to Aetna to operating earnings [1] for our Group Insurance segment:

(Millions)	2016	2015	2014
Net income attributable to Aetna for Group Insurance	$139	$136	$180
Amortization of other acquired intangible assets	—	—	2
Net realized capital gains	(24)	—	(15)
Income tax expense	9	—	4
Operating earnings for Group Insurance	$124	$136	$171

(1) Operating earnings excludes net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2016 compared to 2015

- Net income attributable to Aetna for Group Insurance for 2016 remained relatively flat compared to 2015 primarily due to higher net realized capital gains in 2016, substantially offset by the decrease in operating earnings described below.
- Operating earnings for 2016 declined by $12 million compared to 2015, primarily due to lower underwriting margins (calculated as premiums less current and future benefits) in our disability products and higher operating expenses, partially offset by improved underwriting margins in our long-term care products.
- Our group benefit ratio increased by 40 basis points in 2016 over the prior year, primarily due to lower underwriting margins in our disability products, partially offset by improved underwriting margins in our long-term care products.

Commentary - 2015 compared to 2014

- Net income attributable to Aetna for Group Insurance for 2015 declined by $44 million compared to 2014 primarily due to the decrease in operating earnings described below and higher net realized capital gains in 2014.
- Operating earnings for 2015 declined by $35 million compared to 2014, primarily due to lower underwriting margins in our long-term care and life products as well as lower net investment income, partially offset by higher underwriting margins in our disability products.
- Our group benefit ratio increased by 70 basis points in 2015 over the prior year, primarily due to due to lower underwriting margins in our long-term care and life products partially offset by higher underwriting margins in our disability products.

LARGE CASE PENSIONS

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. The Large Case Pensions segment also includes certain discontinued products.

Operating Summary

				Change 2016 vs. 2015		Change 2015 vs. 2014	
(Millions)	2016	2015	2014	$	%	$	%
Premiums	$39	$32	$ 76	$7	22 %	$(44)	(58)%
Net investment income	226	271	317	(45)	(17)%	(46)	(15)%
Other revenue	9	10	10	(1)	(10)%	—	— %
Net realized capital gains (losses)	10	(15)	2	25	167 %	(17)	(850)%
Total revenue	284	298	405	(14)	(5)%	(107)	(26)%
Current and future benefits	251	284	367	(33)	(12)%	(83)	(23)%
General and administrative expenses	13	13	12	—	— %	1	8 %
Reduction of reserve for anticipated future losses on discontinued products	(128)	—	—	(128)	(100)%	—	— %
Total benefits and expenses	136	297	379	(161)	(54)%	(82)	(22)%
Income before income tax expense (benefit)	148	1	26	147	14,700 %	(25)	(96)%
Income tax expense (benefit)	44	(9)	1	53	589 %	(10)	(1,000)%
Net income including non-controlling interests	104	10	25	94	940 %	(15)	(60)%
Less: Net income attributable to non-controlling interests	—	2	3	(2)	(100)%	(1)	(33)%
Net income attributable to Aetna for Large Case Pensions	$104	$8	$ 22	$96	1,200 %	$(14)	(64)%

The table presented below reconciles net income attributable to Aetna to operating earnings [1] for our Large Case Pensions segment:

(Millions)	2016	2015	2014
Net income attributable to Aetna for Large Case Pensions	$104	$8	$22
Net realized capital (gains) losses	(10)	15	(2)
Reduction of reserve for anticipated future losses on discontinued products	(128)	—	—
Income tax expense (benefit)	48	(6)	1
Operating earnings for Large Case Pensions	$14	$17	$21

(1) Operating earnings excludes net realized capital gains and losses, amortization of other acquired intangible assets and the other items described in the reconciliation in Note 18 “Segment Information” included in Part II, Item 8 of this Annual Report on Form 10-K.

Commentary - 2016 compared to 2015

- Total revenue decreased by $14 million in 2016 compared to 2015, primarily as a result of lower net investment income, partially offset by net realized capital gains during 2016 compared with net realized capital losses during 2015.
- Net income attributable to Aetna for Large Case Pensions for 2016 increased by $96 million compared to 2015. The increase was primarily due to the 2016 reduction of our reserve for anticipated future losses on discontinued products, which was primarily due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve.

Commentary - 2015 compared to 2014

- Total revenue decreased by $107 million in 2015 compared to 2014, primarily as a result of lower net investment income in 2015 and lower premiums due to the discontinuance of certain services under an existing customer contract during 2014, which resulted in a corresponding reduction in current and future benefits during 2015.
- Net income attributable to Aetna for Large Case Pensions for 2015 declined by $14 million compared to 2014, primarily due to net realized capital losses in 2015 compared with net realized capital gains in 2014.

Discontinued Products

Prior to 1993, we sold single-premium annuities ("SPAs") and guaranteed investment contracts ("GICs"), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products to Large Case Pensions customers, and now we refer to these products as discontinued products. We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate losses over their life (which is currently greater than 30 years for SPAs); so we established a reserve for anticipated future losses at the time of discontinuance. In November 2016, the last outstanding GIC matured.

The operating summary for Large Case Pensions above includes revenues and expenses related to our discontinued products, with the exception of net realized capital gains and losses which are recorded as part of current and future benefits. Since we established a reserve for anticipated future losses on discontinued products, as long as our expected future losses remain consistent with prior projections, the results of our discontinued products are applied against the reserve and do not impact net income attributable to Aetna. If actual or expected future losses are greater than we currently estimate, we may increase the reserve, which could adversely impact net income attributable to Aetna. If actual or expected future losses are less than we currently estimate, we may decrease the reserve, which could favorably impact net income attributable to Aetna. In those cases, we disclose such adjustment separately in the operating summary. Management reviews the adequacy of the discontinued products reserve quarterly. As a result of this review, $84 million ($128 million pretax) of the reserve was released in 2016, and no releases were made to the reserve in 2015 or 2014. This reserve release was primarily due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve. The current reserve reflects management's best estimate of anticipated future losses, and is included in future policy benefits on our balance sheet.

Refer to Note 19 "Discontinued Products" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the activity in the reserve for anticipated future losses on discontinued products during 2016, 2015 and 2014.

LIQUIDITY AND CAPITAL RESOURCES

Cash Flows

We meet our operating cash requirements by maintaining liquidity in our investment portfolio, using overall cash flows from premiums, fees and other revenue, deposits and income received on investments, issuing commercial paper, entering into repurchase agreements and obtaining cash advances from the Federal Home Loan Bank of Boston (the "FHLBB") from time to time. We monitor the duration of our investment portfolio of highly marketable debt securities and mortgage loans, and execute purchases and sales of these investments with the objective of having adequate funds available to satisfy our maturing liabilities. Overall cash flows are used primarily for claim and benefit payments, operating expenses, share and debt repurchases, repayment of debt, acquisitions, contract withdrawals and shareholder dividends. We have committed short-term borrowing capacity of $2.0 billion through a revolving credit facility agreement that expires in March 2020.

Presented below is a condensed statement of cash flows for each of the last three years. We present net cash flows used for operating activities and net cash flows provided by investing activities separately for our Large Case Pensions segment because changes in the insurance reserves for the Large Case Pensions segment (which are reported as cash used for operating activities) are funded from the sale of investments (which are reported as cash provided by investing activities). Refer to the Consolidated Statements of Cash Flows included in Part II, Item 8 of this Annual Report on Form 10-K for additional information.

(Millions)	2016	2015	2014	Change 2016 vs. 2015 $	%	2015 vs. 2014 $	%
Cash flows from operating activities							
Health Care and Group Insurance	$3,988	$4,388	$3,601	$(400)	(9)%	$787	22 %
Large Case Pensions	(269)	(522)	(228)	253	48 %	(294)	(129)%
Net cash provided by operating activities	3,719	3,866	3,373	(147)	(4)%	493	15 %
Cash flows from investing activities							
Health Care and Group Insurance	(628)	(1,663)	(2,453)	1,035	62 %	790	32 %
Large Case Pensions	247	636	323	(389)	(61)%	313	97 %
Net cash used for investing activities	(381)	(1,027)	(2,130)	646	63 %	1,103	52 %
Net cash provided by (used for) financing activities	12,134	(1,735)	(1,235)	13,869	799 %	(500)	(40)%
Net increase (decrease) in cash and cash equivalents	$15,472	$1,104	$8	$14,368	1,301 %	$1,096	13,700 %

Commentary - 2016 compared to 2015

- Cash flows provided by operating activities for Health Care and Group Insurance decreased $400 million during 2016 compared to 2015 primarily due to a smaller increase in our health care costs payable liability in 2016 compared with 2015 and decreased operating performance primarily due to higher transaction and integration-related costs, partially offset by the timing of collections of premium receivables.
- Cash flows used for investing activities decreased $646 million in 2016 compared to 2015 primarily due to lower net purchases of investments in 2016.
- Cash flows provided by financing activities increased approximately $13.9 billion in 2016 compared to 2015 primarily due to the issuance of the 2016 senior notes. The increase is also driven by the repayment of debt, settlement of repurchase agreements and repurchases of common shares that occurred in 2015 and did not recur in 2016, partially offset by higher net repayment on interest rate derivatives in 2016.

Commentary - 2015 compared to 2014

- Cash flows provided by operating activities for Health Care and Group Insurance increased $787 million during 2015 compared to 2014 primarily due to improved operating performance and the receipt of our ACA reinsurance recoverables related to 2014, partially offset by the payment of our ACA risk adjustment payable related to 2014 and an increase in the amount we paid for the HIF in September 2015.
- Cash flows used for investing activities decreased $1.1 billion in 2015 compared to 2014 primarily due to lower net purchases of investments and a decline in cash used for acquisitions in 2015.
- Cash flows used for financing activities increased $500 million in 2015 compared to 2014 primarily attributable to the repayment of short-term debt issued in 2014 and net settlements from repurchase agreements in 2015 compared to net proceeds from repurchase agreements in 2014, partially offset by lower common share repurchases in 2015 compared to 2014.

Refer to Notes 9 “Debt” and 13 “Shareholders’ Equity” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information about debt issuances and repayments, share repurchases and dividend payments.

Termination of Merger Agreement and Aetna APA

As a result of the termination of the Merger Agreement, we paid Humana the applicable $1.0 billion Regulatory Termination Fee on February 16, 2017. As a result of the APA Termination Agreement, we paid Molina the applicable termination fee on February 16, 2017, and we expect to pay Molina the applicable transaction costs during the first quarter of 2017. We funded the February 16, 2017 payments with the proceeds of the 2016 senior notes.

2016 Senior Notes

In June 2016, we issued $13 billion of 2016 senior notes. At December 31, 2016, the approximately $13 billion of net proceeds related to the issuance of the 2016 senior notes are invested in highly rated money market fund investments and classified as cash and cash equivalents on our balance sheets. Additionally, in conjunction with the closing of the 2016 senior notes, we

terminated the Bridge Credit Agreement effective June 9, 2016. In accordance with the terms of the 2016 senior notes, on February 14, 2017, following the termination of the Merger Agreement, we issued a notice of redemption for the entire $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017, and we expect to fund the redemption with the proceeds of the 2016 senior notes. As a result of such redemption, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption. Refer to Note 9 “Debt” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on these transactions.

Cash Flow Hedges

Prior to issuing the 2016 senior notes, we entered into various interest rate swaps and treasury rate locks that were designated as cash flow hedges against interest rate exposure related to the forecasted future issuance of fixed-rate debt to be primarily used to finance a portion of the purchase price of the Humana Acquisition. We terminated these hedges in conjunction with the issuance of the 2016 senior notes and paid an aggregate of $348 million to the hedge counterparties upon termination of these interest rate swaps and treasury rate locks. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize the remaining approximately $330 million pretax unamortized portion of the related cash flow hedge losses in our net income upon such redemption. Refer to Note 9 “Debt” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on these transactions.

Other Liquidity Information

From time to time, we use short-term commercial paper borrowings, repurchase agreements and cash advances from the FHLBB to address timing differences between cash receipts and disbursements. At December 31, 2016 and 2015, we did not have any commercial paper outstanding or outstanding advances from the FHLBB. There were no commercial paper borrowings during 2016.

Our debt to capital ratio (calculated as the sum of all short- and long-term debt outstanding (“total debt”) divided by the sum of total Aetna shareholders’ equity plus total debt) was 54% and 33% at December 31, 2016 and 2015, respectively. We continually monitor existing and alternative financing sources to support our capital and liquidity needs, including, but not limited to, debt issuance, preferred or common stock issuance, reinsurance and pledging or selling of assets.

Interest expense was $604 million, $369 million and $334 million for 2016, 2015 and 2014, respectively. The increase in interest expense during 2016 compared to 2015 reflects financing activity associated with the Humana Acquisition. The increase in interest expense during 2015 compared to 2014 reflects the impact of the Bridge Credit Agreement and Term Loan Credit Agreement.

Our current funding strategy for our tax-qualified noncontributory defined benefit pension plan (the “Aetna Pension Plan”) is to contribute an amount at least equal to the minimum funding requirement as determined under applicable law with consideration of factors such as the maximum tax deductibility of such amounts. Refer to Note 10 “Pension and Other Postretirement Plans” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information regarding our current funding strategy for the Aetna Pension Plan.

Contractual Obligations

The following table summarizes certain estimated future obligations by period under our various contractual obligations at December 31, 2016. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2016 (for

example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

The table below also does not include future payments related to the termination of the Merger Agreement, which we expect to make in the first quarter of 2017, including:

- 70% of Molina's transaction costs as specified in the Aetna APA Termination Agreement; and
- The redemption on or about March 16, 2017 of $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes at a redemption price equal to 101% of the aggregate principal amount of such notes, plus accrued and unpaid interest. Those notes are reflected at their respective maturities at issuance in the table below.

We believe that funds from future operating cash flows, together with cash, investments and other funds available under the Facility; from the FHLBB; and from public or private financing sources, will be sufficient to meet our existing commitments as well as our liquidity needs associated with future operations, including our strategic growth initiatives.

(Millions)	2017	2018-2019	2020-2021	Thereafter	Total
Long-term debt obligations, including interest	$2,345	$ 4,345	$ 4,870	$ 19,102	$30,662
Operating lease obligations	143	201	85	84	513
Purchase obligations	269	264	94	2	629
Other liabilities reflected on our balance sheet: [1]					
Future policy benefits [2]	645	1,230	958	3,741	6,574
Unpaid claims [2]	801	554	366	783	2,504
Policyholders' funds [2] [3]	917	83	91	454	1,545
Other liabilities [4]	5,661	314	84	199	6,258
Total	$10,781	$ 6,991	$ 6,548	$ 24,365	$48,685

(1) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $4.0 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of our business.

(2) Total payments of future policy benefits, unpaid claims and policyholders' funds include $506 million, $35 million and $143 million, respectively, of reserves for contracts subject to reinsurance. We expect the assuming reinsurance carrier to fund these obligations and have reflected these amounts as reinsurance recoverable assets on our consolidated balance sheet.

(3) Customer funds associated with group life and health contracts of approximately $2.0 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt and equity securities supporting experience-rated products of $42 million, before tax, have been excluded from the table above.

(4) Other liabilities in the table above include general expense accruals and other related payables and exclude the following:

- Employee-related benefit obligations of $578 million, including our pension and other postretirement and post-employment benefit obligations and certain deferred compensation arrangements. These liabilities do not necessarily represent future cash payments we will be required to make, or such payment patterns cannot be determined. However, other long-term liabilities include expected benefit payments of $338 million over the next ten years for our non-qualified supplemental pension plan and our postretirement benefit plans, which we primarily fund when paid by the plans.
- Deferred gains of $50 million which will be recognized in our earnings in the future in accordance with GAAP.
- Net unrealized capital gains of $165 million, before tax, supporting discontinued products.
- Non-controlling interests supporting our discontinued products of $71 million consisting of third party interests in our investment holdings. This amount does not represent future cash payments we will be required to make.
- Other payables of $45 million.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to Aetna as a holding company, since Aetna is not an HMO or an

insurance company. The additional regulations applicable to our HMO and insurance company subsidiaries are not expected to affect our ability to service our debt, meet our other financing obligations or pay dividends, or the ability of any of our subsidiaries to service other financing obligations. Under applicable regulatory requirements, at December 31, 2016, the amount of dividends that may be paid by our insurance and HMO subsidiaries without prior approval by regulatory authorities was approximately $1.9 billion in the aggregate.

We maintain capital levels in our operating subsidiaries at or above targeted and/or required capital levels and dividend amounts in excess of these levels to meet our liquidity requirements, including the payment of interest on debt and shareholder dividends. In addition, at our discretion, we use these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes we consider advisable.

At December 31, 2016 and 2015, we held investments of $657 million and $690 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of our business. Refer to

Note 4 “Investments” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Off-Balance Sheet Arrangements

We do not have any guarantees or other off-balance sheet arrangements that we believe, based on historical experience and current business plans, are reasonably likely to have a material impact on our current or future operating results, financial position or cash flows (other than the guarantees described in Note 17 “Commitments and Contingencies” included in Part II, Item 8 of this Annual Report on Form 10-K) at December 31, 2016. In addition, refer to Note 4 “Investments” included in Part II, Item 8 of this Annual Report on Form 10-K for additional detail of our variable interest entities at December 31, 2016.

Solvency Regulation

The National Association of Insurance Commissioners (the “NAIC”) utilizes risk-based capital (“RBC”) standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company’s adjusted surplus to its required surplus (the “RBC Ratio”). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2016, the RBC Ratio of each of our primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2016, at that date, each of our active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC’s RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company’s rating.

CRITICAL ACCOUNTING ESTIMATES

We prepare our consolidated financial statements in accordance with GAAP. The application of GAAP requires management to make estimates and assumptions that affect our consolidated financial statements and related notes. The accounting estimates described below are those we consider critical in preparing our consolidated financial statements. We use information available to us at the time the estimates are made; however, as described below, these estimates could change materially if different information or assumptions were used. Also, these estimates may not ultimately reflect the actual amounts that occur.

Health Care Costs Payable

At December 31, 2016 and 2015, 86% and 85%, respectively, of health care costs payable are estimates of the ultimate cost of claims that have been incurred but not yet reported to us and of those which have been reported to us but not yet paid (collectively “IBNR”). The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables and accruals for state assessments. We develop our estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Refer to Note 2 “Summary of Significant Accounting Policies - Health Care Costs Payable” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our reserving methodology.

During 2016 and 2015 we observed an increase in our completion factors relative to those assumed at the prior year end. After considering the claims paid in 2016 and 2015 with dates of service prior to the fourth quarter of the previous year, we observed the assumed incurred claims weighted average completion factors were 28 and 35 basis points higher, respectively, than previously estimated, resulting in a reduction of $230 million and $282 million in

2016 and in 2015, respectively, in health care costs payable that related to the prior year. We have considered the pattern of changes in our completion factors when determining the completion factors used in our estimates of IBNR at December 31, 2016. However, based on our historical claim experience, it is reasonably possible that our estimated weighted average completion factor may vary by plus or minus 18 basis points from our assumed rates, which could impact health care costs payable by approximately plus or minus $212 million pretax.

Also during 2016 and 2015, we observed that our health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2016 and 2015 with claim incurred dates for the fourth quarter of the previous year, we observed health care costs that were 6.5% lower for each fourth quarter than previously estimated, resulting in a reduction of $534 million in 2016 and $559 million in 2015 in health care costs payable that related to the prior year.

We consider historical health care cost trend rates together with our knowledge of recent events that may impact current trends when developing our estimates of current health care cost trend rates. When establishing our reserves at December 31, 2016, we increased our assumed health care cost trend rates for the most recent three months by 5% from health care cost trend rates

recently observed. However, based on our historical claim experience, it is reasonably possible that our estimated health care cost trend rates may vary by plus or minus 3.5% from our assumed rates, which could impact health care costs payable by plus or minus $304 million pretax.

Health care costs payable as of December 31, 2016 and 2015 consisted of the following products:

(Millions)	2016	2015
Commercial	$3,273	$3,252
Government	3,285	3,054
Total health care costs payable	$6,558	$6,306

Other Insurance Liabilities

We establish insurance liabilities other than health care costs payable for benefit claims primarily related to our Group Insurance segment. We refer to these liabilities as other insurance liabilities. These liabilities primarily relate to our life, disability and long-term care products.

Life and Disability

The liabilities for our life and disability products reflect estimates of the ultimate cost of benefit claims that have been reported to us but not yet paid, benefit claims that have been incurred but not yet reported to us, and future policy benefits earned under insurance contracts. We develop our estimate of these reserves and the related benefit expenses using actuarial principles and assumptions that consider, among other things, discount, resolution and mortality rates. Completion factors are also evaluated when estimating our reserves for claims incurred but not yet reported for life products. We also consider the benefit payments from the U.S. Social Security Administration for which our disability members may be eligible and which may offset our liability for disability claims (this is known as the Social Security offset). Each period, we estimate these factors, to the extent relevant, based primarily on historical data, and use these estimates to determine the assumptions underlying our reserve calculations. Given the extensive degree of judgment and uncertainty used in developing these estimates, it is possible that our estimates could develop either favorably or unfavorably.

The discount rate is the interest rate at which future benefit cash flows are discounted to determine the present value of those cash flows. The discount rate we select is a critical estimate, because higher discount rates result in lower reserves. We determine the discount rate based on the current and estimated future yield of the asset portfolio supporting our life and disability reserves. If the discount rate we select in estimating our reserves is lower (higher) than our actual future portfolio returns, our reserves may be higher (lower) than necessary. The discount rates we selected for life insurance waiver of premiums and long-term disability reserves at December 31, 2016 were 40 basis points lower than the rate selected at December 31, 2015, primarily due to the decrease in projected portfolio rates of return. The discount rates we selected for life insurance waiver of premiums and long-term disability reserves at December 31, 2015 were consistent with the rates used at 2014. Based on our historical experience, it is reasonably possible that the assumed discount rates for our life and disability reserves may vary by plus or minus 50 basis points from year to year. A 50 basis point decrease in the discount rates selected for both our life insurance waiver of premium and disability reserves would have increased current and future life and disability benefit costs by $38 million pretax for 2016.

For disability claims and a portion of our life claims, we must estimate the timing of benefit payments, which takes into consideration the maximum benefit period and the probabilities of recovery (i.e., recovery rate) or death (i.e., mortality rate) of the member. Benefit payments may also be affected by a change in employment status of a disabled member, for example, if the member returns to work on a part-time basis. Estimating the recovery and mortality rates of our members is complex. Our actuaries evaluate our current and historical claim patterns, the timing and amount of

any Social Security offset (for disability only), as well as other factors including the relative ages of covered members and the duration of each member's disability when developing these assumptions. For disability reserves, if our actual recovery and mortality rates are lower (higher) than our estimates, our reserves will be lower (higher) than required to cover future disability benefit payments. For certain life insurance premium waiver reserves, if the actual recovery rates are lower (higher) than our estimates or the actual mortality rates are higher (lower) than our estimates, our reserves will be lower (higher) than required to cover future life benefit payments. We use standard industry tables and our historical claim experience to develop our estimated recovery and mortality rates. Claim reserves for our disability and life products are sensitive to these assumptions. Our historical experience has been that our recovery or mortality rates for our life and disability reserves vary by less than ten percent during the course of a year. A ten percent less (more) favorable assumption for our recovery or mortality rates would have increased (decreased) current and future life and disability benefit costs by $71 million pretax for 2016. When establishing our reserves at December 31, 2016, we set our estimates of recovery and mortality rates based on recent experience. Refer to Note 2 "Summary of

Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our reserving methodology.

Long-term Care

We established reserves for future policy benefits for the long-term care products we issued based on the present value of estimated future benefit payments less the present value of estimated future net premiums. In establishing this reserve, we evaluated assumptions about mortality, morbidity, lapse rates and the rate at which new claims would be submitted to us. We estimated the future policy benefits reserve for long-term care products using these assumptions and actuarial principles. For long-term care insurance contracts, we use our original assumptions throughout the life of the policy and do not subsequently modify them unless we deem the reserves to be inadequate. A portion of our reserves for long-term care products also reflect our estimates relating to future payments to members currently receiving benefits. These reserves are estimated primarily using recovery and mortality rates, as described above.

Premium Deficiency Reserves on our Health Care and Group Insurance products

We recognize a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. Any such reserves established would normally cover expected losses until the next policy renewal dates for the related policies. In the second and third quarters of 2016, we recorded premium deficiency reserves totaling $85 million related to anticipated future losses for the 2016 coverage year in our individual Commercial products. We did not have any premium deficiency reserves for our Health Care or Group Insurance business at December 31, 2016 or 2015.

Large Case Pensions Discontinued Products Reserve

We discontinued certain Large Case Pensions products in 1993 and established a reserve to cover losses expected during the run-off period. Since 1993, we have made several adjustments resulting in a reduction to this reserve that have increased net income attributable to Aetna. These adjustments occurred primarily because our investment experience as well as our mortality and retirement experience have been better than the experience we projected at the time we discontinued the products. In 2016, we released $84 million ($128 million pre-tax) of this reserve primarily due to favorable retirement experience as well as favorable investment performance compared to assumptions we previously made in estimating the reserve. There was no adjustment of this reserve in 2015 or 2014. There can be no assurance that adjustments to the discontinued products reserve will occur in the future. Future adjustments could positively or negatively impact net income attributable to Aetna.

Recoverability of Goodwill and Other Acquired Intangible Assets

We have made acquisitions that included a significant amount of goodwill and other intangible assets. When we complete an acquisition, we apply the acquisition method of accounting, which among other things, requires the recognition of goodwill (which represents the excess cost of the acquisition over the fair value of net assets acquired and identified intangible assets). Goodwill is subject to an annual (or under certain circumstances more frequent) impairment test based on its estimated fair value. Other intangible assets that meet certain criteria are amortized over their useful lives, except for the valuation of business acquired which amortizes in proportion to estimated premiums over the expected life of the acquired contracts, and are also subject to a periodic impairment test. Historically, for these impairment evaluations, we have used an implied fair value approach, which used a discounted cash flow analysis and other valuation methodologies. Beginning in 2017, we adopted, on a prospective basis, the recently issued accounting standards update related to the methodology utilized to evaluate goodwill impairment. This update simplifies the methodology used to perform our annual, or interim, goodwill impairment evaluations. Our evaluation will be performed by comparing the estimated fair value of a reporting unit with its carrying amount. An impairment charge would be recognized when the carrying amount exceeds the estimated fair value of the reporting unit. These impairment evaluations use many assumptions and estimates in determining an impairment loss, including certain

assumptions and estimates related to future earnings. If we do not achieve our earnings objectives, the assumptions and estimates underlying these impairment evaluations could be adversely affected, which could result in an asset impairment charge that would negatively impact our operating results. There were no impairment losses recognized in any of the three years ended December 31, 2016, 2015 or 2014.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans
We sponsor defined benefit pension plans (“pension plans”) and OPEB plans for our employees and retirees. Effective December 31, 2010, our employees no longer earn future pension service credits in the Aetna Pension Plan, although the Aetna Pension Plan will continue to operate and account balances will continue to earn annual interest credits. Employees covered by our non-qualified supplemental pension plan stopped accruing benefits effective January 1, 2007, although interest credits continue to be credited on these cash balance accounts.

Major assumptions used in the accounting for our pension plans include the expected return on plan assets, if applicable, mortality rates and the discount rate. We select our assumptions based on our information and market indicators, and we evaluate our assumptions at each annual measurement date (December 31, for each year presented). A change in any of our assumptions would have an effect on our pension and OPEB plan costs. A discussion of our assumptions used to determine the expected return on plan assets and mortality rates can be found in Note 10 “Pension and Other Postretirement Plans” included in Part II, Item 8 of this Annual Report on Form 10-K.

The discount rates we used in accounting for our pension and OPEB plans were calculated using a yield curve as of our annual measurement date. Each yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds (that is, bonds with an average rating of AA based on ratings from Standard & Poor’s, Fitch, and the equivalent ratings from Moody’s). We project the benefits expected to be paid from each plan at each point in the future based on each participant’s current service (but reflecting expected future pay increases). These projected benefit payments are then discounted to the measurement date using the corresponding rate from the yield curve. A lower discount rate increases the present value of benefit obligations. In 2016, we decreased our weighted average discount rate to 4.22% for our pension plans from the 4.50% used at the measurement date in 2015. In 2016, we decreased our weighted average discount rate on OPEB plans to 4.12% from the 4.39% used at the measurement date in 2015. A one-percentage point decrease in the assumed discount rate would decrease our annual pension costs by $10 million after-tax and would have a negligible effect on our annual OPEB costs.

Beginning in 2017, we changed the approach used to estimate the interest cost component of net periodic benefit cost for pension and OPEB for plans that utilize a yield curve approach. Historically, we estimated the interest cost using a single weighted-average discount rate derived from the yield curve used to measure the projected benefit obligation. With this refinement, we now measure interest costs by applying the specific spot rates along that yield curve to the relevant projected cash flows for each component. We believe the new approach provides a more precise measurement of interest cost. This refinement has no effect on the measurement of our plan obligations. We have accounted for this refinement as a change in accounting estimate and, accordingly, have accounted for it on a prospective basis beginning in 2017.

At December 31, 2016, our pension and OPEB plans had aggregate pretax accumulated actuarial losses of approximately $2.5 billion. Accumulated actuarial losses are primarily due to an increase in the present value of future plan obligations driven by lower interest rates and improving mortality trends as well as investment results below assumed returns in 2008. The accumulated actuarial loss is amortized over the weighted-average expected life of pension plan participants (estimated to be up to 28 years at December 31, 2016 for the pension plans) and the expected life of OPEB plan participants (estimated to be up to 16 years at December 31, 2016) to the extent the loss is outside of a corridor established in accordance with GAAP. The corridor is established based on the greater of 10% of the plan assets or 10% of the projected benefit obligation. At December 31, 2016, approximately $1.9 billion of the actuarial loss was outside of the corridor, which will result in amortization of $44 million after-tax in our 2017 pension and OPEB expense.

The expected return on plan assets and discount rate assumptions discussed above impacted the reported net periodic benefit costs and benefit obligations of our pension and OPEB plans, but did not impact the required contributions to these plans, if any. Refer to Note 10 “Pension and Other Postretirement Plans” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on our defined benefit pension and other postretirement employee benefit plans, including our current funding strategy.

Other-Than-Temporary Impairment of Debt Securities

We regularly review our debt securities to determine whether a decline in fair value below the carrying value is other-than-temporary. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of

the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in our operating results, and the amount of the non-credit related component is included in other comprehensive income, unless we intend to sell the security or it is more likely than not that we will be required to sell the security prior to its anticipated recovery of its amortized cost basis. We analyze all facts and circumstances we believe are relevant for each investment when performing this analysis, in accordance with applicable accounting guidance promulgated by the Financial Accounting Standards Board and the U.S. Securities and Exchange Commission (the "SEC").

Among the factors we consider in evaluating whether a decline is other-than-temporary are whether the decline in fair value results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, we determine whether we intend to sell the debt security or if it is more likely than not that we will be required to sell the debt security before

recovery of its amortized cost basis. If either case is true, we recognize an other-than-temporary impairment ("OTTI"), and the cost basis/carrying amount of the debt security is written down to fair value.

Debt securities in an unrealized loss position for which we believe we will not recover the amortized cost due to the quality of the debt security or the creditworthiness of the issuer are categorized as credit-related OTTI.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from our projections and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Revenue Recognition and Allowance for Estimated Terminations and Uncollectible Accounts
Our revenue is principally derived from premiums and fees billed to customers in the Health Care and Group Insurance segments. In Health Care, revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in our records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. In Group Insurance, premium for group life and disability products is recognized as revenue, net of allowances for uncollectible accounts, over the term of coverage. Amounts received before the period of coverage begins are recorded as unearned premiums.

Health Care billings may be subsequently adjusted to reflect enrollment changes due to terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, we estimate the amount of future retroactivity and adjust the recorded revenue accordingly. In each period, we also estimate the amount of uncollectible receivables and establish an allowance for uncollectible amounts. We base such estimates on historical trends, premiums billed, the amount of contract renewal activity during the period and other relevant information. As information regarding actual retroactivity and uncollectible amounts becomes known, we refine our estimates and record any required adjustments to revenues in the period they arise. A significant difference in the actual level of retroactivity or uncollectible amounts compared to our estimated levels would have a significant effect on our operating results.

Additionally, premium revenue subject to the ACA's minimum MLR rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. We estimate the minimum MLR rebates by projecting MLRs for certain markets, as defined by the ACA, for each state in which each of our insurance entities operate. The claims and premiums used in estimating such rebates are modified for certain adjustments allowed by the ACA and include a statistical credibility adjustment for those states with a number of members that is not statistically credible.

Furthermore, premium revenue subject to the ACA's permanent risk adjustment program transfers funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of our qualified plan members relative to the average risk of members of other qualified plans in comparable markets, we estimate our ultimate risk adjustment receivable or payable for the current calendar year and reflect the pro-rata year-to-date impact as an adjustment to our premium revenue. In this analysis, we consider the estimate of the average risk of members of other qualified plans in comparable markets the most critical assumption. We estimate this assumption using management's best estimates, which are based on various data sources, including but not limited to market risk data compiled by third party sources as well as pricing and other regulatory inputs. Refer to Note 2 "Summary of Significant Accounting Policies" included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on each of the ACA's risk adjustment, risk corridor and reinsurance programs.

NEW ACCOUNTING STANDARDS

Refer to Note 2 “Summary of Significant Accounting Policies” included in Part II, Item 8 of this Annual Report on Form 10-K for a discussion of recently issued accounting standards.

REGULATORY ENVIRONMENT

General

Our operations are subject to comprehensive United States federal, state and local and comparable multiple levels of international regulation in the jurisdictions in which we do business. The laws and rules governing our business and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The new U.S. presidential administration and the control of the U.S. Congress by a single political party increase the likelihood of significant changes in those laws and rules, including the ACA. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry’s business and reporting practices.

We must obtain and maintain regulatory approvals to price, market and administer many of our products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight ("CCIIO") and the Department of Labor ("DOL"), as well as state health, insurance, managed care and Medicaid agencies and state boards of pharmacy have broad authority to take one or more of the following actions:

- Grant, suspend and revoke our licenses to transact business;
- Suspend or exclude us from participation in government programs;
- Suspend or limit our authority to market products;
- Regulate many aspects of the products and services we offer, including the pricing and underwriting of many of our products and services;
- Audit us and our performance of our contracts, which can, among other things, affect our Medicare Advantage plans' and Medicare Part D Prescription Drug plans' ("PDPs'") star ratings;
- Assess damages, fines and/or penalties;
- Terminate our contract with the government agency and/or withhold payments from the government agency to us;
- Impose retroactive adjustments to premiums and require us to pay refunds to the government, customers and/or members;
- Restrict our ability to conduct acquisitions or dispositions;
- Require us to maintain minimum capital levels in our companies and monitor our solvency and reserve adequacy;
- Regulate our investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude our plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by the U.S. Department of Health and Human Services ("HHS") or the applicable state.

Our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators. See "Audits and Investigations" below in this MD&A - Regulatory Environment for additional information on these matters.

The ACA made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate efforts in 2017 and beyond to substantially modify, repeal or replace the ACA, we expect aspects of the ACA to continue to significantly impact our business operations and operating results, including our pricing, our MBRs and the geographies in which our products are available. The ACA has presented us with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including Public Exchanges, required minimum MLRs in Commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." The effects of these changes are reflected in our operating results. If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2020.

We have dedicated and expect to continue to be required to dedicate significant resources and incur significant expenses during 2017 to implement and comply with ACA-related requirements and changes to the ACA as well as state level health care reform. While most of the significant aspects of the ACA became effective during or prior to

2014, significant parts of the ACA, including aspects of nondiscrimination requirements, continue to evolve through the promulgation of executive orders, regulations and guidance. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response changes to, or repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, we cannot predict the impact on us of future changes to the ACA. It is reasonably possible that

repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on our business operations and operating results.

Potential repeal of the ACA, ongoing legislative and regulatory changes to the ACA, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of the ACA (including risk corridors and the ACA's Cost Sharing Subsidy program), the results of the 2016 presidential, congressional and state level elections, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Examples of recent legislative and regulatory changes include: the January 20, 2017 executive order relating to the ACA; the November 2016 HHS announcement that risk corridor collections for the 2015 program year will be applied first to amounts owed to plans for the 2014 program year; the May 2016 final regulations relating to the ACA's non-discrimination requirements; the December 2015 suspension of the HIF for 2017 and two year delay of the "Cadillac" tax on high-cost employer-sponsored health coverage; the October 2015 PACE, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that the ACA's risk corridor receivables for the 2014 program year would only be funded at 12.6%. With respect to pending litigation, in May 2016, the U.S. District Court for the District of Columbia ruled that the U.S. Department of Health and Human Services does not have the authority to make payments under the ACA's Cost Sharing Subsidy program. Implementation of this decision has been stayed pending appeal. A final ruling that adversely impacts the Cost Sharing Subsidy program could cause significant adverse selection in individual Public Exchange products and instability in the individual Public Exchange marketplace and could have a material adverse effect on our business, cash flows, financial condition and operating results as well as hinder our ability to offer Public Exchange products.

As described above, the availability of funding for the ACA's temporary risk corridor program is an example of this uncertainty. We continue to believe that receipt of any risk corridor payment from HHS for the 2016 or 2015 program year and receipt of such payments in excess of the announced prorated amount for the 2014 program year are uncertain. At December 31, 2016, we had an immaterial receivable for the remaining 2014 program year prorated amount that had not been collected from HHS and no receivable for either of the 2015 or 2016 program years. In addition, these limited risk corridor payments created additional instability in the marketplace for individual Commercial products in 2016 and going forward by contributing to decisions by health plans to change or stop offering their Public Exchange products. 2016 was the last program year for the ACA's risk corridor program. On-going uncertainty regarding the funding of ACA-related programs and subsidies can be expected to create additional instability in the marketplace.

In addition to efforts to amend, repeal or replace the ACA and the related regulations, the federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and our business. We cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or the ACA or the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements we and other health plans are paid by the federal government for our Medicare members, among other sources. While not all-inclusive, the following are some of the key provisions of the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2017. We continue to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on our business operations and operating results:

- States can open Public Exchanges to large group employers beginning January 1, 2017.
- The ACA's non-discrimination requirements for benefit plans beginning January 1, 2017.

- Closure of the gap in coverage for Medicare Part D prescription drug coverage (the so-called “donut hole”) which began to close in 2010 and will incrementally close until the coverage gap is eliminated in 2020.
- Continuing reductions to Medicare Advantage payment rates for payments to us and other plans which are fully phased-in for 2017 and the linking of Medicare Advantage payments to a plan’s CMS quality performance ratings or “star ratings.” Any inability on our part to achieve and maintain acceptable star ratings could have a material adverse effect on our Medicare operating results and/or the geographies in which our Medicare products are available.
- The imposition on us and other health insurers, health plans and other market participants of significant fees, assessments and taxes, including the industry-wide reinsurance assessment of $5 billion in 2016 and an annual non-tax deductible industry-wide $11.3 billion HIF in 2016, which will be zero in 2017 and, as currently enacted, $14.3 billion in 2018 and increase annually thereafter. Our share of the 2016 ACA fees, assessments and taxes was $979 million, which includes our share of the HIF, which was $837 million. As a result of the 2017 suspension of the HIF and the

termination of the ACA's reinsurance and risk corridor provisions at the end of 2016, we do not expect our share of the applicable 2017 ACA fees, assessments and taxes to be significant.

- A non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2020.
- Reduced funding for Medicaid expansion beginning in 2017.

The ACA also specifies minimum MLRs for our Commercial and Medicare Insured products, specifies required Commercial benefit designs, limits Commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit our ability to appropriately increase our health plan premium rates. This in turn could adversely affect our ability to continue to participate in certain product lines and/or geographies we serve today.

In addition, the ACA ties a portion of each Medicare Advantage plan's reimbursement to the achievement of favorable CMS quality performance measures ("star ratings"). Since 2015, only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, our Medicare Advantage plans' operating results in 2017 and going forward will be significantly affected by their star ratings. For additional information on CMS's stars program and our related performance, see "Medicare" below in this MD&A - Regulatory Environment.

In 2016, state legislatures focused on state budgets and taxes (including new assessments on health care premiums), provider network composition and provider directory accuracy requirements, pharmacy benefit and drug coverage requirements, Medicaid reforms and health care delivery system transformation. At the state level, all 50 U.S. states and the District of Columbia will hold regular legislative sessions in 2017. We expect additional state level legislation and regulatory activity that impacts our businesses to be enacted in 2017, including potentially significant changes in individual, small group and Medicaid products and/or programs in response to or in anticipation of reduced federal funding. In addition, independent of federal efforts, we expect many states to continue to consider legislation or regulations that affect privately-financed health insurance arrangements and/or public programs, including imposing requirements on the composition of our provider networks and the accuracy of our provider directories, requiring changes to health benefit product structure, mandating specific benefit coverages, and enhancing consumer transparency on provider network composition as well as cost and quality of care. For example, regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards or procedures for reviewing proposed premium rate changes, as well as imposing taxes on insurers and other health plans to finance Public Exchanges, Medicaid and other state programs. If any elements of the ACA are repealed at the federal level, we expect that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

We cannot predict what provisions legislation or regulation will contain in any state or what effect legislation or regulation will have on our business operations or operating results, but the effect could be materially adverse.

Health Care Regulation

General

Federal, state, local and foreign governments have adopted comprehensive laws and regulations that govern our business activities in various ways. Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. These laws and regulations, including the ACA, restrict how we conduct our business and result in additional burdens

and costs to us.

In addition to the expanded regulation created by the ACA discussed above, significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, health care provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks, pharmacy and pharmacy benefit management operations and financial position (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of our regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition,

some of our business and related activities may be subject to preferred provider organization ("PPO"), managed care organization, utilization review or third-party administrator-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain health care provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for our delivery of services, payment of claims, fraud prevention, protection of consumer health information, payment for covered benefits and services and escheatment of funds to states. Our pharmacy benefit management ("PBM") services suppliers, including CaremarkPCS Health, L.L.C. (and its predecessors, collectively "CVS"), also are subject to extensive federal and state regulation, including many of the items described above.

Pricing and Underwriting Restrictions

Pricing and underwriting regulation by states limits our underwriting and rating practices and those of other health insurers, particularly for small employer groups and individuals. Since 2014, as a result of the ACA, health insurers cannot vary small group or individual premium rates based on individual members' characteristics except for geography and limited variation for age and tobacco use. Since 2016, as a result of the ACA, states have the ability to expand the small group rating category to cover groups of up to 100 employees. Pricing and underwriting laws and regulations vary by state. In general, they apply to certain customer segments and limit our ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict our ability to price for the risk we assume and/or reflect reasonable costs in our pricing.

The ACA expanded the premium rate review process by, among other things, requiring our rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding 10% (or a state specified threshold). HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect our ability to price for the risk we assume, which could adversely affect our medical benefit ratios and operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds our projections.

The ACA also specifies minimum MLRs of 85% for large group commercial products, 80% for individual and small group commercial products and 85% for Medicare Advantage and Medicare Part D plans. Beginning in 2017, Medicaid managed care products, including those we offer, also are subject to a minimum MLR of 85% under a final rule issued by CMS in 2016. Because the ACA and the Medicaid minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing its various restrictions. For Medicaid managed care and commercial products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings for commercial products, require prior approval of premium rates for commercial products, or impose other requirements related to minimum MLR. For example, Texas has expanded from 50 to 100 the maximum size of "small groups" that are subject to its minimum MLR requirements, and New York, New Jersey and California all have established state-specific minimum MLR requirements. Minimum MLR requirements and similar actions further limit the level of margin we can earn in our Insured business while leaving us exposed to medical costs that are higher than those reflected in our pricing. We also may be subject to significant fines, penalties, premium refunds and litigation if we fail to comply with minimum MLR laws and regulations. In addition, if a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years (including on a retrospective basis), it will become ineligible to participate in open enrollment. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years (including on a retrospective basis), it will be terminated by CMS.

In addition, we requested significant increases in our premium rates in our individual and small group Health Care businesses for 2017 and expect to continue to request significant increases in those rates for 2018 and beyond in order

to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect adverse selection in our products, particularly in individual and small group products, which we expect to continue and potentially worsen in 2017 with the expiration of the ACA's risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of these laws and regulations also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups or individuals based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage. In addition, HHS' rules on rates impose additional public disclosure requirements on any rate filings that exceed the "reasonableness" threshold and require additional review of those rates.

In addition, a number of states provide for a voluntary reinsurance mechanism to spread small group risk among participating insurers and other carriers. In a small number of states, participation in this pooling mechanism is mandatory for all small group carriers. In general, we have elected not to participate in voluntary pools. However, even in the voluntary pool states, we may be subject to certain supplemental assessments related to the state's small group experience. Core elements of the ACA were designed to reduce or eliminate reliance on these state pooling mechanisms. If those elements of the ACA are modified or repealed, states may reinstate or expand their pooling requirements, including mandatory participation.

HIPAA Administrative Simplification, GLBA and Other Privacy, Security and Confidentiality Requirements
Federal, state and international privacy and security requirements change periodically because of legislation, regulations and judicial or administrative interpretation. The regulations under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") and the ACA, also impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors.

HIPAA's administrative simplification requirements apply to self-funded group health plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically ("Covered Entities"). Regulations adopted to implement administrative simplification also require that "business associates" acting for or on behalf of these Covered Entities be contractually obligated to meet HIPAA standards. The administrative simplification regulations establish significant criminal penalties and civil sanctions for noncompliance.

The HIPAA privacy regulations adopted by HHS establish limits on the use and disclosure of medical records and other individually identifiable health information (protected health information or "PHI") by Covered Entities. Further, ARRA requires us and other Covered Entities to report any breaches of PHI to impacted individuals and to HHS and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Business associates (e.g., entities that provide services to health plans, such as electronic claims clearinghouses, print and fulfillment vendors, consultants, and us for the administrative services we provide to our ASC customers) must also comply with certain HIPAA provisions. In addition, ARRA establishes greater civil and criminal penalties for Covered Entities and business associates who fail to comply with HIPAA's provisions and gives new enforcement rights to state attorneys general. Additional regulations under HIPAA remain pending. We will continue to assess the impact of these regulations on our business as they are issued.

The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may apply to us and other Covered Entities, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. Complying with additional state requirements requires us to make additional investments beyond those we have made to comply with the HIPAA regulations. HHS also has adopted security regulations designed to protect member health information from unauthorized use or disclosure. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

The HIPAA privacy regulations provide patients with rights to understand and control how their health information is used. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. The GLBA regulations apply to health, life and disability insurance. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection.

The Cybersecurity Information Sharing Act of 2015 (“CISA”) encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency. States are also starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with possibly conflicting cybersecurity regulations, which may differ from state to state, would require significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. Widely-reported large scale U.S. commercial data breaches increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of

our businesses, including the consumer business we are creating, our privacy and security strategy and our web-based and mobile assets.

Other Legislative Initiatives and Regulatory Initiatives

In addition to the ACA, HIPAA and ARRA measures discussed above, the U.S. federal and state governments, as well as governments in other countries where we do business, continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system. For example:

- Under the Budget Control Act of 2011 (the "BCA") and the American Taxpayer Relief Act of 2012 (the "ATRA") significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. CMS's April 2016 final notice for 2017 Medicare Advantage benchmark payment rates (the "Final Notice") provides for rate cuts to the employer group waiver program that will begin in 2017 and be fully phased in for 2018 as well as adverse changes to the risk adjustment mechanism for dual eligible beneficiaries and the Medicare Advantage star rating program. Overall, we project the benchmark payment rates for 2017 in the Final Notice will decrease funding for our Medicare Advantage businesses by less than 1 percent in 2017 compared to 2016. This 2017 rate decrease adds to the challenge we face from the impact of the increasing cost of medical care, the HIF beginning in 2018 (as currently enacted) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. We cannot predict future Medicare or Medicaid funding levels or the impact that future federal budget actions or entitlement program reform, if it occurs, will have on our business, operations or operating results, but the effects could be materially adverse, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results.
- A number of states have enacted or introduced legislation or regulations requiring life insurers to take additional steps to identify unreported deceased policyholders and make other changes to their claim payment and related escheat practices. For additional information on these life insurance matters, refer to "Life and Disability Insurance" below in this MD&A - Regulatory Environment.
- The Department of Labor has issued final rules that will increase the administrative expense of and our related liability for processing claims for disability benefits. These rules are scheduled to become effective January 1, 2018.

Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:

- Restricting our ability to limit providers' participation in our networks and/or remove providers from our networks by imposing network adequacy requirements or otherwise (including in our Medicare, Public Exchange and other Commercial products).
- Stabilizing the marketplace for individual Commercial insurance products.
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
- Reducing federal and/or state government funding of government-sponsored health programs in which we participate, including Medicare and Medicaid programs.
- Restricting or mandating health plan or life insurer claim processing, review, payment and/or related procedures.
- Mandating coverage for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
- Imposing requirements and restrictions on the administration of pharmacy benefits, including restricting or eliminating the use of formularies for prescription drugs; restricting our ability to require members to obtain drugs through a mail order or specialty pharmacy; restricting our ability to place certain specialty or other drugs in the higher cost tiers of our pharmacy formularies; restricting our ability to make changes to drug formularies and/or our clinical programs; limiting or eliminating rebates on pharmaceuticals; restricting our ability to configure our

pharmacy networks; and restricting or eliminating the use of certain drug pricing methodologies.

- Regulating electronic connectivity.
- Mandating or regulating the disclosure of health care provider fee schedules and other data about our payments to providers.

- Mandating or regulating disclosure of health care provider outcome and/or efficiency information.
- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize.
- Assessing the medical device status of health information technology ("HIT") products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with U.S. Food and Drug Administration ("FDA") requirements in relation to some of these products, solutions and/or tools.
- Imposing payment levels for services rendered to our members by health care providers who do not have contracts with us.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Imposing additional requirements on the processing of claims for disability benefits.
- Amending or supplementing the Employee Retirement Income Security Act of 1974 ("ERISA") to impose greater requirements on the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

Some of the changes, if enacted, could provide us with business opportunities. However, it is uncertain whether we can counter the potential adverse effects of such potential legislation or regulation, including whether we can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying our systems to implement any enacted legislation or regulations.

Our business also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs, reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA") and creates a Federal Insurance Office ("FIO") within the U.S. Department of the Treasury (the "Treasury") with powers that include information-gathering and subpoena authority. Although the FIO does not have authority over health insurance, it may have authority over other parts of our business, primarily life insurance.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA are also regulated by the Treasury and the Internal Revenue Service (the "IRS").

We also may be adversely impacted by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing group and individual life insurance payment practices, bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Medicare

Our Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. Our Medicare PDP and Medicare Supplement products are complementary products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

We continue to expand the Medicare markets we serve and Medicare products we offer. We expect to further expand our Medicare service area and products in 2017 and are seeking to substantially grow our Medicare membership, revenue and operating results over the next several years, including through growth in our Medicare Supplement products, which products are regulated at the state level. The organic expansion of the Medicare markets we serve and Medicare products we offer and the Medicare-related provisions of the ACA significantly increase our exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the

various Medicare programs in which we participate, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, sequestration began in 2013 and resulted in an automatic reduction in Medicare reimbursements to health plans of not more than 2% of total program costs per year through 2024. In addition, the ACA as currently enacted contains further significant reductions in the reimbursements we receive for our Medicare Advantage members which were fully phased-in for 2017. Since the 2014 contract year, the ACA also has required minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years (including on a retrospective basis), it will become ineligible to participate in open enrollment. If a Medicare Advantage contracts pays rebates for five consecutive years (including on a retrospective basis), it will be terminated by CMS.

CMS's Final Notice provides for rate cuts to the employer group waiver program that will begin in 2017 and be fully phased in for 2018 as well as adverse changes to the risk adjustment mechanism for dual eligible beneficiaries and the Medicare Advantage star rating program. Overall, we project the benchmark payment rates for 2017 in the Final Notice will decrease funding for our Medicare Advantage businesses by less than 1 percent in 2017 compared to 2016. This 2017 rate decrease adds to the challenge we face from the impact of the increasing cost of medical care, the HIF beginning in 2018 (as currently enacted) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids.

Our Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to us and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. We have invested significant resources to comply with Medicare standards, and our Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit us from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of our Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare or dual eligible programs and/or institute other sanctions against us if we fail to comply with CMS regulations or our Medicare contractual requirements.

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare Advantage and PDP beneficiaries. For example, CMS currently conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. In December 2015, CMS released a request for information ("RFI") for a significant expansion of the RADV audit program. As described in the RFI, CMS would use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. Refer to "CMS Actions" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for information on certain pending CMS audits.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Our star ratings and past performance scores are adversely affected by compliance issues that arise in our Medicare operations, such as our distribution of inaccurate information regarding which pharmacies were part of our Medicare network and related $1 million civil monetary penalty in 2015 and notices of non-compliance and warning letters in 2016.

Since 2015, Medicare Advantage plans must have an overall star rating of four stars or higher (out of five stars) to qualify for a quality bonus in their basic premium rates. CMS released our 2017 star ratings in October 2016. Our 2017 star ratings will be used to determine which of our Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2018. Based on our membership at December 31, 2016, 92% of our Medicare Advantage members were in plans with 2017 star ratings of at least 4.0 stars. CMS will release updated stars ratings in October 2017 that will be used to determine the portion of our Medicare Advantage membership that will reside in plans with ratings of four stars or higher and qualify for bonus payments in 2019. In 2017 and going forward, our Medicare Advantage plans' operating results will continue to be significantly affected by their star ratings. CMS continues to revise the star ratings system to make it harder to achieve four stars or more. Despite our success in improving our star ratings and other quality measures for 2017 and the continuation of our improvement efforts, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. 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.

We cannot predict future Medicare funding levels or the impact that future federal budget actions or entitlement program reform, if it occurs, will have on our business, operations or operating results, but the effects could be materially adverse, particularly on our Medicare and/or Medicaid revenues, medical benefit ratios and operating results. For example, the Federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. We currently believe that the payments we receive and will receive in the near term are adequate to justify our continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, we expect CMS, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, either of which could adversely affect us.

Medicaid

We are seeking to substantially grow our Medicaid and dual eligible businesses over the next several years. As a result, we also are increasing our exposure to changes in government policy with respect to and/or regulation of the various Medicaid and dual eligible programs in which we participate, including changes in the amounts payable to us under those programs.

In April 2016, CMS issued a final rule that overhauls the entire Medicaid managed care delivery system. The final rule represents the first update to Medicaid managed care regulations since 2002. Among other things the final rule requires Medicaid products to have a minimum MLR of 85%; establishes a Medicaid managed care quality rating system; and establishes provider network adequacy requirements. The minimum MLR requirements are effective beginning in 2017.

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, thirty-one states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Starting in 2017, federal funding for expanded Medicaid coverage is decreasing and proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2017 and beyond, including the possibility of converting federal Medicaid support to block grants and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation may adversely affect Medicaid payment rates, our revenues and our Medicaid membership in those states.

The economic aspects of the Medicaid and dual eligible business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states are also considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in our networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for us to continue program participation due to state and federal budgetary constraints and continuing efforts to reduce health care costs. In addition, our Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

Our Medicaid and dual eligible products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit our performance to determine compliance with CMS contracts and regulations. Our Medicaid products, dual eligible products and Children's Health Insurance Program ("CHIP") contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services we provide to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on

behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to us and other participants in Medicaid and dual eligible programs, including requirements that we submit encounter data to the applicable state agency, are extensive, complex and subject to change. We have invested significant resources to comply with these standards, and our Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine us, withhold payments to us, seek premium and other refunds, terminate our existing contracts, elect not to award us new contracts or renew our existing contracts, prohibit us from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of our Medicaid or dual eligible products, exclude us from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions against us if we fail to comply with CMS or state regulations or our contractual requirements.

We cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can we predict the impact those changes will have on our business operations or operating results, but the effects could be materially adverse.

Federal Employees Health Benefits Program

Our subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. We also manage certain FEHB plans on a "cost-plus" basis. The OPM conducts periodic audits of its contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under its insured contracts and costs allocated pursuant to its cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against us if we fail to comply with the FEHB program requirements.

The Employee Retirement Income Security Act of 1974

The provision of services to certain employee benefit plans, including certain Health Care, Group Insurance and Large Case Pensions benefit plans, is subject to ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the IRS and the U.S. Department of Labor (the "DOL"). ERISA regulates certain aspects of the relationships between us and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities also are subject to regulation and/or review by the DOL under ERISA. ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts.

Some of our Health Care, Group Insurance and Large Case Pensions products and services and related fees we charge are also subject to potential issues raised by certain judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, we may have ERISA fiduciary duties with respect to certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those assets are subject to conflict of interest and other restrictions, and we must provide certain disclosures to policyholders annually. We must comply with these restrictions or face substantial penalties.

HMO, Insurance Holding Company and Other State Laws

A number of states, including Pennsylvania and Connecticut, regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require us and our subsidiaries to maintain certain levels of equity and require prior regulatory approval of material intercompany transfers of assets as well as transactions between the regulated companies and their affiliates, including their parent holding companies. We expect the states in which our insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of our insurance companies and HMOs.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2016, the RBC level of each of our insurance and HMO subsidiaries was above the level that would require regulatory action.

In addition, changes to regulations or the interpretation of those regulations due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to recent and expected payor insolvencies, could negatively impact our business in various ways, including through increases in solvency fund

assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

For information regarding restrictions on certain payments of dividends or other distributions by our HMO and insurance company subsidiaries, refer to Note 13 “Shareholders’ Equity” included in Part II, Item 8 of this Annual Report on Form 10-K.

The holding company laws for the states of domicile of Aetna and certain of its subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as our parent company, Aetna Inc.) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Our workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. Our workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. Our workers' compensation customers include insurance carriers and TPA's who also are regulated at the state level. The laws and regulations applicable to us and other participants in the workers' compensation business are extensive, complex and subject to change. We have invested significant resources to comply with these standards, and our workers' compensation compliance efforts will continue to require significant resources. We may be subject to significant fines, penalties and litigation if we fail to comply with those laws and regulations.

Audits and Investigations

We and our vendors and other downstream entities typically have been, are currently and may in the future be involved in various governmental investigations, audits, examinations, reviews, subpoenas and other requests for information, the intensity and scope of which continue to increase. These include routine, regular and special investigations, audits, examinations and reviews by, as well as subpoenas and other requests for information from, CMS, HHS (including the Office of Civil Rights), various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the CCIIO, the Office of the Inspector General (the "OIG"), the OPM, the DOL, the Treasury, the FDA, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice (the "DOJ"), the U.S. Federal Trade Commission (the "FTC"), the Office of Foreign Assets Control ("OFAC") of the Treasury, U.S. attorneys and other state, federal and international governmental authorities.

For example, certain of our Medicare Advantage plans are currently under audit for, among other things, compliance with coding and other requirements under the Medicare risk adjustment model; federal and state auditors are challenging our Commercial business compliance with the ACA's minimum MLR requirements; federal auditors are challenging our FEHB plans' compliance with the OPM's FEHB program specific minimum MLR requirements; and our Commercial business is subject to audits related to the ACA's risk adjustment and reinsurance data since those programs were implemented in 2014. HHS also has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security. Such government actions may, among other things, prevent or delay us from implementing planned premium rate increases and have resulted and may result in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds to members or the government, withholding of premium payments to us by government agencies, payments under insurance policies prior to those payments being due under the terms of the policy, assessments of damages, civil or criminal fines or penalties (including under the federal false claims act (the "False Claims Act")), or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

A significant number of states are investigating life insurers' and health insurers' claims payment and related escheat practices. For additional information on these life insurance matters, refer to "Life and Disability Insurance" below in this MD&A - Regulatory Environment.

Refer to "Litigation and Regulatory Proceedings" in Note 17 "Commitments and Contingencies" included in Part II, Item 8 of this Annual Report on Form 10-K for more information regarding pending audits and investigations.

Federal and State Reporting

We are subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the state and federal level. Our ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. We are and will continue to be required to modify our information systems, dedicate significant resources and incur

significant expenses to comply with these requirements. However, we cannot eliminate the risks of unavailability of or errors in our reports.

Fraud, Waste and Abuse Laws

Federal and state governments have made investigating and prosecuting health care fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a health care provider, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to us and other participants in these public-sector programs are complex and subject to change. Although our compliance program is designed to meet all statutory and regulatory requirements, our policies and procedures are frequently under review and subject to updates, and our training and education programs continue to evolve. We have

invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

Federal and State Laws and Regulations Governing Submission of Information and Claims to Agencies
We are subject to federal and state laws and regulations that apply to the submission of information and claims to various government agencies. For example, the False Claims Act provides, in part, that the federal government may bring a lawsuit against any person or entity who the government believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. There also is False Claims Act liability for knowingly or improperly avoiding repayment of an overpayment received from the government and/or failing to promptly report and return any such overpayment. The federal government, whistleblowers and some courts have taken the position that claims presented in violation of other statutes, such as the federal anti-kickback statute, may be considered a violation of the False Claims Act. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products sold on Public Exchanges. Violations of the False Claims Act are punishable by treble damages and penalties of up to a specified dollar amount per false claim. In addition, a special provision under the False Claims Act allows a private person (for example, a “whistleblower” such as a disgruntled current or former competitor, member or employee) to bring an action under the False Claims Act on behalf of the government alleging that a company has defrauded the federal government and permits the private person to share in any settlement of, or judgment entered in, the lawsuit.

A number of states, including states in which we operate, have adopted their own false claims acts and whistleblower provisions that are similar to the False Claims Act. From time to time, companies in the health and related benefits industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

Product Design and Administration and Sales Practices
State and/or federal regulatory scrutiny of health care benefit and life insurance product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. Refer to “Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools” in Note 17 “Commitments and Contingencies” included in Part II, Item 8 of this Annual Report on Form 10-K for more information on the expected liquidation of Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, “Penn Treaty”) and certain assessments to which our HMOs are subject. If Penn Treaty is placed in liquidation in the first half of 2017, we expect to record an estimated liability and expense of approximately $230 million pretax at the time of such event. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

Regulation of Pharmacy Operations

CVS has provided certain PBM services to us and certain of our customers and members since January 1, 2011. As amended, our PBM agreement with CVS has a term ending in December 2022, although we have certain termination rights beginning in January 2020. Express Scripts also provides certain PBM services to certain of our customers and members under an agreement with a term ending in 2017 for a portion of our Commercial and Medicaid members. Express Scripts also provided PBM services to a portion of our Medicare members in 2015.

Notwithstanding our contracting with our PBM services suppliers, we remain responsible to regulators and members for the delivery of PBM services. In addition, we continue to operate two mail order pharmacy facilities and one specialty pharmacy facility (our “Pharmacies”) and utilize certain pharmacies of our PBM services suppliers. Our Pharmacies dispense pharmaceuticals throughout the U.S. and are participating providers in Medicare, Medicare Part D and various Medicaid programs. The pharmacy practice is generally regulated at the state level by state boards of pharmacy. Our Pharmacies are

required to be licensed in the state where they are located, as well as the states that require registration or licensure of mail order pharmacies with the state's board of pharmacy or similar regulatory body. Our Pharmacies also must register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances and must comply with applicable Medicare, Medicaid and other provider rules and regulations, including the False Claims Act, state false claims acts and federal and state anti-kickback laws. Our PBM services suppliers' owned and contracted pharmacies are subject to these same licensing requirements and other laws and regulations. The loss or suspension of any such licenses or registrations could have a material adverse effect on our ability to meet our contractual obligations to our customers, which could, in turn, have a material adverse effect on our pharmacy business and/or operating results.

Regulation of Pharmacy Benefit Management Operations

Our PBM services are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and federal and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of, and/or changes to drug formularies, maximum allowable cost list pricing, average wholesale prices and/or clinical programs; disclosure of data to third parties; drug utilization management practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of our Pharmacies (including audits of our Pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by us or one of our PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on our operating results.

Life and Disability Insurance

Our life and disability insurance operations are subject to extensive regulation. Changes in these regulations, such as expanding the definition of disability or mandating changes to claim payment, determination and/or settlement practices, could have a material adverse impact on our life insurance and/or disability insurance operations and/or operating results. Legislation has been enacted or introduced in a number of states requiring life insurers to take additional steps to identify unreported deceased policy holders, and make other changes to their claim payment and related escheat practices, including consultation of certain databases. A significant number of states are investigating life insurers' claims payment and related escheat practices, and these investigations have resulted in significant charges to earnings by other life insurers in connection with related settlement agreements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

Consumer Protection Laws

Our consumer business which began serving members on January 1, 2016 and certain of our other businesses participate in direct-to-consumer activities, and we increasingly offer mobile and web-based solutions to our members and to other consumers. We are therefore subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. In particular, the FTC is aggressively exercising its enforcement authority in the areas of consumer privacy and data security with a focus on web-based, mobile products and "big data." As a result of the widely-reported large scale U.S. commercial data breaches during 2016 and prior years, the FTC and state regulators have increased their enforcement activity in these regimes. These enforcement developments will impact the design, management and operation of our businesses, including our consumer business, our privacy and security strategy and our web-based and mobile assets.

International Regulation

We expect to continue to expand our Health Care operations in foreign countries through both organic growth and acquisitions. We currently have insurance licenses in several foreign jurisdictions and do business directly or through local affiliations in numerous countries around the world. The impact on our international operations and results of the United Kingdom's pending exit from the European Union ("EU") is uncertain.

Our international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which will apply across the EU effective May 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and

repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of our operations into foreign countries increases our exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. We also are subject to applicable anti-corruption laws of the jurisdictions in which we operate. In many countries outside the U.S., health care professionals are employed by the government. Therefore, our dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the SEC and the DOJ have increased their enforcement activities with respect to the FCPA. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. We have internal control policies and procedures and conduct training and compliance programs for our employees to deter prohibited practices. However, if our employees or agents fail to comply with applicable laws governing our international operations, we may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions. See "As we expand our international operations, we will increasingly face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations. Our exposure to these risks is expected to increase" in "Risk Factors" included in Part I, Item 1A of this Annual Report on Form 10-K for a discussion of the risks related to operating globally.

Anti-Money Laundering Regulations

Certain of our lines of business are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their compliance with the regulations. We also may be subject to anti-money laundering laws in non-U.S. jurisdictions where we operate.

Office of Foreign Assets Control

We also are subject to regulation by OFAC. OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, we may be subject to similar regulations in the non-U.S. jurisdictions in which we operate.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Our earnings and financial position are exposed to interest rate risk, credit quality risk and market valuation risk.

Evaluation of Interest Rate and Credit Quality Risk

We manage interest rate risk by seeking to maintain a tight match between the durations of our assets and liabilities when appropriate. We manage credit risk by seeking to maintain high average credit quality ratings and diversified sector exposure within our debt securities portfolio. In connection with our investment and risk management objectives, we also use derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. Our use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject us to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, we expect these instruments to reduce overall risk.

Investments

Our investment portfolio supported the following products at December 31, 2016 and 2015:

(Millions)	2016	2015
Experience-rated products	$1,154	$1,157
Discontinued products	2,929	3,059
Remaining products	20,796	20,464
Total investments	$24,879	$24,680

Investment risks associated with our experience-rated and discontinued products generally do not impact our operating results. The risks associated with investments supporting experience-rated pension and annuity products in our Large Case Pensions business are assumed by the contract holders and not by us (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals. The distributions on our experience-rated products consisted of scheduled contract maturities and benefit payments and contract holder withdrawals of $90 million, $285 million and $153 million, respectively, in the years ended December 31, 2016, 2015 and 2014. Participant-directed withdrawals were not material in the years ended December 31, 2016, 2015 or 2014. Refer to Note 19 “Discontinued Products” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information related to our discontinued products.

Debt and Equity Securities

The debt securities in our investment portfolio had an average credit quality rating of A at both December 31, 2016 and 2015, with approximately $5.2 billion and $5.0 billion rated AAA at December 31, 2016 and 2015, respectively. The debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) were $1.6 billion and $1.4 billion at December 31, 2016 and 2015, respectively (of which 12% and 13% at December 31, 2016 and 2015, respectively, supported our experience-rated and discontinued products).

At December 31, 2016 and 2015, we held $812 million and $956 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 3% and 4%, respectively, of our total investments. These securities had an average credit quality rating of AA at both December 31, 2016 and 2015 with the guarantee. These securities had an average credit quality rating of A at both December 31, 2016 and 2015 without the guarantee. We do not have any significant concentration of investments with third party guarantors (either direct or indirect).

At both December 31, 2016 and 2015, less than 1% of our investment portfolio was comprised of investments that were either European sovereign, agency, or local government debt of countries which, in our judgment based on an analysis of market-yields, are experiencing economic, fiscal or political strains such that the likelihood of default may be higher than if those factors did not exist.

We generally classify our debt and equity securities as available for sale, and carry them at fair value on our balance sheets. At both December 31, 2016 and 2015, 1% of our debt and equity securities were valued using inputs that reflect our own assumptions (categorized as Level 3 inputs in accordance with GAAP). Refer to Note 5 “Fair Value” included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the methodologies and key assumptions we use to determine the fair value of investments.

For additional information related to our investments, see Note 4 “Investments” included in Part II, Item 8 of this Annual Report on Form 10-K.

We regularly review our debt securities to determine if a decline in fair value below the carrying value is other-than temporary. If we determine a decline in fair value is other-than-temporary, we will write down the carrying value of the debt security. The amount of the credit-related impairment is included in our operating results, and the non-credit related component is included in other comprehensive income unless we intend to sell the debt security or it is more likely than not that we will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. Accounting for other-than-temporary impairment (“OTTI”) of our debt securities is considered a critical accounting estimate. Refer to “Critical Accounting Estimates - Other-Than-Temporary Impairment of Debt Securities” of MD&A included in Part II, Item 7 of this Annual Report on Form 10-K for additional information.

Evaluation of Market Risks

We regularly evaluate our risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit

ratings/spreads. We also regularly evaluate the appropriateness of investments relative to our management-approved investment guidelines (and operate within those guidelines) and the business objectives of our portfolios.

On a quarterly basis, we review the impact of hypothetical net losses in our investment portfolio on our consolidated near-term financial position, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for us. We have estimated the impact on the fair value of our market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which we believe represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate

movements for our intermediate-term available-for-sale debt securities) and an immediate decrease of 15% in prices for domestic equity securities.

Assuming an immediate 100 basis point increase in interest rates and immediate decrease of 15% in the prices for domestic equity securities, the theoretical decline in the fair values of our market sensitive instruments at December 31, 2016 is as follows:

- The fair value of our long-term debt would decline by $1.1 billion ($1.6 billion pretax). Changes in the fair value of our long-term debt do not impact our financial position or operating results.
- The theoretical reduction in the fair value of our investment securities partially offset by the theoretical reduction in the fair value of our interest rate sensitive liabilities would result in a net decline in fair value of $322 million ($495 million pretax) related to our non-experience-rated products. Reductions in the fair value of our investment securities would be reflected as an unrealized loss in equity, as we classify these securities as available for sale. We do not record our liabilities at fair value.

Based on our overall exposure to interest rate risk and equity price risk, we believe that these changes in market rates and prices would not materially affect our consolidated near-term financial position, operating results or cash flows as of December 31, 2016.

Evaluation of Operational Risks

We also face certain operational risks, including risks related to information security, including cybersecurity. We and our vendors have experienced a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted virus infections, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, malware or injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. We are dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis our systems and processes that are designed to mitigate the information security risks we face and protect the security of our computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, destroy data, disrupt or degrade service, sabotage systems or cause other damage. The impact of the cyber attacks we have experienced through December 31, 2016 has not been material to our operations or operating results. Our Board and Audit Committee are regularly informed regarding our information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data

Index to Consolidated Financial Statements

Consolidated Balance Sheets

(Millions)	At December 31, 2016	2015
Assets:		
Current assets:		
Cash and cash equivalents	$17,996	$2,524
Investments	3,046	3,015