Risk Factors Comparison 2024-02-15 to 2023-02-16 Form: 10-K

Legend: **New Text** ~~Removed Text~~ Unchanged Text Moved Text Section

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. These estimates involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends. Accordingly, our reserves may be insufficient. We use a substantial portion of our revenues to pay the costs of health care services delivered to our members, including claims payments, capitation payments to providers (predetermined amounts paid to cover services), estimates of future payments to hospitals and others for medical care provided to our members, and various other costs. Generally, premiums in the health care business are fixed for one- year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves, including premium deficiency reserves where appropriate. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include: • increased use of medical facilities and services, and the increased cost of such services; • increased use or cost of prescription drugs, including specialty prescription drugs; • the introduction of new or costly treatments, prescription drugs, or new technologies; • our membership mix; • variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes; • changes in the demographic characteristics of an account or market; • changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals; • changes in our purchase discounts or **rebates received from manufacturers and wholesalers; •** pharmacy volume rebates received from drug manufacturers ~~and wholesalers~~ , which **in Medicare Part D** are **fully reported** ~~generally passed on~~ to ~~clients in~~ **CMS and factored into member premium pricing and CMS reimbursement to** the **plan** ~~form of steeper price discounts~~ ; • catastrophes, including acts of terrorism, public health emergencies, epidemics or pandemics (such as ~~the spread of~~ COVID- 19 **),** or natural disasters (such as hurricanes and earthquakes) which could occur more frequently or with more intense effects as a result of the impact of global climate change; • medical cost inflation; and • government mandated benefits, member eligibility criteria, or other legislative, judicial, or regulatory changes. Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program. While we proactively attempt to effectively manage our operating expenses, increases or decreases in staff- related expenses, any costs associated with exiting products, additional investment in new products (including our opportunities in the Medicare programs, state- based contracts, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well- being product offerings, acquisitions, new taxes and assessments, inflation, and implementation of regulatory requirements may increase our operating expenses. Failure to adequately price our products or estimate sufficient benefits payable or effectively manage our operating expenses, may result in a material adverse effect on our results of operations, financial position, and cash flows. We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors through the Medicare Annual Enrollment Period. ~~In addition, contracts for the sale of group commercial products are generally bid upon or renewed annually.~~ While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative **and regulatory** reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical and administrative costs. The policies and decisions of the federal and state governments regarding the Medicare Advantage and Prescription Drug Plans, military **services** and Medicaid programs in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the premiums or other revenues to us under the programs, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, health care services, and other costs associated

with these programs. Legislative or regulatory actions, such as changes to the programs in which we participate, those resulting in a reduction in premium payments to us, an increase in our cost of administrative and health care services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows. Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected. If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives, which are of particular importance given the concentration of our revenues in these products, our state- based contracts strategy, the growth of our CenterWell businesses, and our integrated care delivery model, our business may be materially adversely affected. In addition, there can be no assurances that we will be successful in maintaining or improving our Star ratings in future years. Our future performance depends in large part upon our ability to execute our strategy, including opportunities created by the expansion of our Medicare programs, our strategy with respect to state- based contracts, including those covering members dually eligible for the Medicare and Medicaid programs, the growth of our pharmacy, ~~provider services~~ **primary care** , and home solutions businesses, and the successful implementation of our integrated care delivery model. We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. The growth of our Medicare products is an important part of our business strategy, and the attendant concentration of revenues intensifies the risks to us inherent in Medicare products. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. The achievement of star ratings of 4- star or higher qualifies Medicare Advantage plans for premium bonuses. Our Medicare Advantage plans' operating results may be significantly affected by their star ratings. Despite our operational efforts to improve our star ratings, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our star ratings. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and / or reduce profit margins. If we fail to properly maintain the integrity of our data, to strategically maintain existing or implement new information systems, or to protect our proprietary rights to our systems, our business may be materially adversely affected. Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. These systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop and integrate new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences, and even with such resources there is no assurance that we will be able to do so. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to improve service levels or maintain effectively our information systems and data integrity, we could have operational disruptions, problems in determining medical cost estimates and establishing appropriate pricing, customer and health care provider disputes, regulatory or other legal problems, difficulty preventing and detecting fraud, have increases in operating expenses, loss of existing customers, difficulty in attracting new customers, or other adverse consequences, each of which may result in a material adverse effect on our results of operations, financial position, and cash flows. We depend on independent third parties for significant portions of our systems- related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results. We rely on our agreements with customers and service providers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. The misappropriation of our proprietary information could hinder our ability to market and sell products and services and may result in a material adverse effect on our results of operations, financial position and cash flows. If we, and the third- party service providers on whom we rely, are unable to defend our information technology ~~security~~ systems against cybersecurity attacks **, contain such attacks when they occur,** or prevent other privacy or data security incidents that result in security breaches that disrupt our operations or in the unintentional dissemination of sensitive personal information or proprietary or confidential information, we could be exposed to significant regulatory fines or penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows. In the ordinary course of our business, we process, store and transmit large amounts of data, and rely on third- party service providers to do the same, including sensitive personal information as well as proprietary or confidential information relating to our business or a third- party **with which we do business** . We have been, and will likely continue to be, regular targets of attempted cybersecurity attacks and other security threats and may be **, and have been,** subject to breaches of our information technology ~~security~~ systems **, including breaches of the information technology systems of third- party service providers** . Although the impact of such attacks has not been material to our operations or results of operations, financial position, or cash flow through December 31, ~~2022~~ **2023** , we can provide no assurance that we will be able to detect, prevent, or contain the effects of such cybersecurity attacks or other information security risks or threats **, or that such an attack will not be material to our business,** in the future. A

cybersecurity attack may penetrate our layered security controls and **lead to the** ~~misappropriate~~ **misappropriation of** or compromise **of** sensitive personal information or proprietary or confidential information ~~or that of third- parties~~ , create system disruptions, cause shutdowns, or deploy viruses, ~~worms~~ **ransomware** , and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our ~~IT security~~ **information technology** systems, or the security of third- party service providers, could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential ~~data~~ **information** or intellectual property, operational or business delays resulting from the disruption of our IT systems **, extortion attempts** , or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders. The costs to detect, prevent, eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures or the security measures of third- party service providers, and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third- parties, ~~could~~ **can** expose our associates' or members' private information and result in the risk of financial or medical identity theft, or expose us or other third- parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business. We are involved in various legal actions and governmental and internal investigations, any of which, if resolved unfavorably to us, could result in substantial monetary damages or changes in our business practices. Increased litigation and negative publicity could increase our cost of doing business. We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment compensation and other labor and employment practice suits, employee benefit claims, stockholder suits and other securities laws claims, intellectual and other property claims, and tort claims. In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management, and offering of products and services. These include and could include in the future: claims relating to the methodologies for calculating premiums; claims relating to the denial of health care benefit payments; claims relating to the denial or rescission of insurance coverage; challenges to the use of some software products used in administering claims; claims relating to our administration of our Medicare Part D offerings; medical malpractice actions brought against our employed providers or affiliated physician-owned professional groups, **or against our health plans** based on our medical necessity decisions or brought against us on the theory that we are liable for a third- party providers' alleged malpractice; claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients; allegations of anti- competitive and unfair business activities; provider disputes over compensation or non- acceptance or termination of provider contracts; ~~disputes related to ASO business, including actions alleging claim administration errors;~~ false claims litigation, such as qui tam lawsuits, brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government or retained overpayments from the government, among other allegations, resulting from coding and review practices under the Medicare risk- adjustment model; claims related to the failure to disclose some business practices; claims relating to customer audits and contract performance; claims relating to dispensing of drugs associated with our in- house dispensing pharmacies; and professional liability claims arising out of the delivery of healthcare and related services to the public. In some cases, substantial non- economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act and other statutes may be sought. While we currently have insurance coverage for some of these potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future. The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation, and governmental review of industry practices. These factors may materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, may increase the regulatory burdens under which we operate, and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows. See" Legal Proceedings and Certain Regulatory Matters" in Note 17 to the audited Consolidated Financial Statements included in Item 8.- Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty. As a government contractor, we are exposed to risks that may materially adversely affect our business or our willingness or ability to participate in government health care programs. A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military **services** , and Medicaid programs. These programs accounted for approximately ~~88~~ **91** % of our total premiums and services revenue for the year ended December 31, ~~2022~~ **2023** . These programs involve various risks, as described further below. • At December 31, ~~2022~~ **2023** , under our contracts with CMS we provided health insurance coverage to approximately ~~771~~ **851** , ~~900~~ **300** individual Medicare Advantage members in Florida. These contracts accounted for approximately 14 % of our total premiums and services revenue for the year ended December 31, ~~2022~~ **2023** . The loss of these and other CMS contracts (which are generally renewed annually) or significant changes in the Medicare Advantage and Prescription Drug Plan programs as a result of legislative or regulatory action, including changes to the Part D prescription drug benefit design **(such as the changes to plan sponsor liability across the different Part D coverage phases that will apply beginning in plan year 2025)** or reductions in premium payments to us or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows. • Our military services business, which accounted for approximately 1 % of our

total premiums and services revenue for the year ended December 31, ~~2022~~ **2023** , primarily consisted of the TRICARE T2017 East Region contract. The T2017 East Region contract **comprises** ~~is a consolidation of the former T3 North and South Regions, comprising~~ 32 states and **covers** approximately ~~six~~ **6. 0** million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. **The** ~~On December 23, 2022, the Department of Defense (" DoD ") exercised its option to extend the~~ T2017 East Region contract, ~~adding Option Periods 6 & 7, and exercised Option Period 6~~ which **was originally set to expire on December 31, 2022, was subsequently** ~~extends~~ **extended by** the ~~T2017~~ **United States Department of Defense, or DoD, and is currently scheduled to expire on December 31, 2024 unless further extended. In December 2022, we were awarded the next generation of TRICARE Managed Care Support Contracts, or T- 5, for the updated TRICARE East Region by the DoD. The T- 5** East Region contract ~~through December 31~~ **comprises 24 states and Washington** , ~~2023~~ **D** . **C.** ~~On December 22~~ , ~~2022, we were notified by~~ **and covers approximately 4. 6 million beneficiaries. The transition period for** the **T- 5** ~~DoD that we were awarded the new~~ contract **began** ~~for the TRICARE East Region, with delivery of health care services expected to commence~~ in **January** 2024 **and will overlap the final year of the T2017 contract** . The ~~next generation~~ **T- 5** East Region contract ~~awards may be subject~~ **includes certain provisions pursuant** to ~~protests by unsuccessful bidders before~~ **which we have guaranteed certain discounts to expected costs over** the **life** ~~U. S. Court~~ of ~~Federal Claims~~ **the contract** . The loss of the ~~current~~ T2017 **or T- 5** East Region ~~contract~~ **contracts** ~~or an overturn of the award of the new East Region contract to us~~ , should either occur **, or our failure to deliver on the contractually agreed discounts** , may have a material adverse effect on our results of operations, financial position, and cash flows. • CMS uses a risk- adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk- adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan' s membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare- covered benefits to an enrollee with a" national average risk profile." That baseline payment amount is adjusted to account for certain demographic characteristics and health status of our enrolled members. Under the risk- adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk- adjustment model uses the diagnosis data, collected from providers, to calculate the health status- related risk- adjusted premium payment to MA plans, which CMS further adjusts for coding pattern differences between the health plans and the government fee- for- service (FFS) program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our health status- adjusted payment received from CMS under the actuarial risk- adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. CMS and the Office of the Inspector General of Health and Human Services, or HHS- OIG, perform audits of various companies' risk adjustment diagnosis data submissions. We refer to these audits as Risk- Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices that influence the calculation of health status- related premium payments to MA plans. In 2012, CMS released an MA contract- level RADV methodology that would extrapolate the results of each CMS RADV audit sample to the audited MA contract' s entire health status- related risk adjusted premium amount for the year under audit. In doing so, CMS recognized " that the documentation standard used in RADV audits to determine a contract' s payment error (medical records) is different from the documentation standard used to develop the Part C risk- adjustment model (FFS claims). " To correct for this difference, CMS stated that it would apply a " Fee- for- Service Adjuster (FFS Adjuster) " as " an offset to the preliminary recovery amount. " This adjuster would be " calculated by CMS based on a RADV- like review of records submitted to support FFS claims data. " CMS stated that this methodology would apply to audits beginning with PY 2011. Humana relied on CMS' s 2012 guidance in submitting MA bids to CMS. Humana also launched a " Self- Audits " program in 2013 that applied CMS' s 2012 RADV audit methodology and included an estimated FFS Adjuster. Humana completed Self- Audits for PYs 2011- 2016 and reported results to CMS. In October 2018, however, CMS issued a proposed rule announcing possible changes to the RADV audit methodology, including elimination of the FFS Adjuster. CMS proposed applying its revised methodology, including extrapolated recoveries without application of a FFS Adjuster, to RADV audits dating back to PY 2011. On January 30, 2023, CMS published a final rule related to the RADV audit methodology (Final RADV Rule). The Final RADV Rule confirmed CMS' s decision to eliminate the FFS Adjuster. The Final RADV Rule states CMS' s intention to extrapolate results from CMS and HHS- OIG RADV audits beginning with PY 2018, rather than PY 2011 as proposed. However, CMS' s Final RADV Rule does not adopt a specific sampling, extrapolation or audit methodology. CMS instead stated its general plan to rely on " any statistically valid method... that is determined to be well- suited to a particular audit. " ~~Humana is considering its legal options with respect to CMS' s changed position on the FFS Adjuster and seeking clarity regarding our compliance obligations in light of the Final RADV Rule.~~ We believe that the Final RADV Rule fails to address adequately the statutory requirement of actuarial equivalence **and violates the Administrative Procedure Act (" APA ")** . **CMS failed to meet its legal obligations in the federal rulemaking process to give a reasoned justification for the rule or provide a meaningful opportunity for public comment. They also chose to apply the rule retroactively** ~~Further~~ -- **rather than prospectively** , **as required by law.** Humana' s actuarially certified bids through PY 2023 preserved Humana' s position that CMS should apply an FFS Adjuster in any RADV audit that CMS intends to extrapolate. We expect CMS to apply the Final RADV Rule, including the first application of extrapolated audit results to determine audit settlements without a FFS Adjuster, to CMS and HHS- OIG RADV audits conducted for PY 2018 and subsequent years. The Final RADV Rule, including the lack of a FFS Adjuster, and any related regulatory, industry or company reactions, could have a material adverse effect on our results of operations, financial

position, or cash flows. In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS that may, either individually or in the aggregate, be material. As such, the result of these reviews may have a material adverse effect on our results of operations, financial position, or cash flows. ~~As we explore~~ **On September 1, 2023, Humana Inc. and Humana Benefit Plan of Texas, Inc. filed suit against the United States Department of Health and Human Services, and Xavier Becerra in his official capacity as Secretary, in the United States District** ~~our~~ **Court** ~~legal options and compliance obligations~~ , ~~we~~ **Northern District of Texas, Fort Worth Division seeking a determination that the Final RADV Rule violates the APA and should be set aside. We** remain committed to working alongside CMS to promote the integrity of the MA program as well as affordability and cost certainty for our members. It is critical that MA plans are paid accurately and that payment model principles, including the application of a FFS Adjuster, are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows. • Our CMS contracts which cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS. The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a " risk corridor "). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain **until CMS completes the applicable final payment year reconciliation** , including member eligibility differences with CMS **incurred allowable drug costs after rebates and other discounts, and low- income subsidy amounts** . Reinsurance and low- income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS' s portion of claims costs which exceed the member' s out- of- pocket threshold, or the catastrophic coverage level. Low- income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co- payment amounts above the out- of- pocket threshold for low- income beneficiaries. Monthly prospective payments from CMS for reinsurance and low- income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS' s prospective subsidies against actual prescription drug costs we paid is made after the end of the applicable year. Settlement of the reinsurance and low- income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS' s claims edit processes due to various reasons, including discrepancies in eligibility or classification of low- income members. To the extent our data does not pass CMS' s claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low- income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS' s share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS. Further, legislative or regulatory changes to how actual prescription drug costs are reported or calculated or other changes to the Part D prescription drug benefit design may lower reinsurance or low- income cost subsidies paid by CMS and may have a material adverse effect on our results of operations, financial position, or cash flows. • **Our primary care and home health businesses derive a substantial portion of their revenues from third- party payors and directly from the federal and state governments through participation in fee- for- service Medicare. This concentration of revenues subjects these businesses to reductions in Medicare reimbursement rates or changes in the rules governing the Medicare program, including changes to CMS' s risk adjustment model that may apply to our primary care business through its contracts with third- party payors. It is reasonably possible that such changes in reimbursement rates or changes to the Medicare programs in which our primary care and home health business participate may have a material adverse effect on our results of operations, financial position, or cash flows. •** We are subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations, including audits of risk adjustment data, are also conducted by state attorneys general, CMS, HHS-OIG, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or temporary or permanent exclusion from participating in various government health care programs (such as Medicare and Medicaid), including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services. Our business activities are subject to substantial government regulation. New laws or regulations, or legislative, judicial, or regulatory changes in existing laws or regulations or their manner of application could increase our cost of doing business and may have a material adverse effect on our results of operations, or cash flows. New Laws

or Regulations, or Future Legislative, Judicial or Regulatory Changes We are and will continue to be regularly subject to new laws and regulations, changes to existing laws and regulations, and judicial determinations that impact the interpretation and applicability of those laws and regulations. The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law), the Families First Coronavirus Response Act (the " Families First Act "), the Coronavirus Aid, Relief, and Economic Security Act (the " CARES Act "), and the Inflation Reduction Act of 2022 (the " Inflation Reduction Act "), and related regulations, are examples of laws which have enacted significant reforms to various aspects of the U. S. health insurance industry, including among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state- based exchanges coupled with programs designed to spread risk among insurers, the introduction of plan designs based on set actuarial values, and changes to the Part D prescription drug benefit design. It is reasonably possible that these laws and regulations, as well as other current or future legislative, judicial or regulatory changes ~~(including further legislative or regulatory action taken in response to COVID- 19)~~ , including restrictions on our ability to manage our provider network **,** **market and sell our products,** or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage business profitability to our non- Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, increases in regulation of our prescription drug benefit businesses, or changes to the Part D prescription drug benefit design **(and uncertainty arising from the implementation of these changes)** may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows. Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace these laws and regulations, including the Health Care Reform Law or declare all or certain portions of these laws and regulations unconstitutional or contrary to law, create uncertainty for our business, and we cannot predict when, or in what form, such legislative changes or judicial determinations may occur. Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm- Leach- Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for the confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent. These regulations set standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their non- public personal information is used, including an opportunity to" opt out" of certain disclosures. The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened and strengthened the scope of the privacy and security regulations of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other requirements, the HITECH Act and HIPAA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights. In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e. g., entities that provide services to health plans and providers). Corporate Practice of Medicine and Other Laws As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician- owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee- splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows. Anti- Kickback, Physician Self-Referral, and Other Fraud and Abuse Laws We are subject to various federal and state healthcare fraud and abuse laws including

the federal False Claims Act (the " False Claims Act "), the federal anti- kickback statute (the " Anti- Kickback Statute "), the federal " Stark Law, " and related state laws. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participating in the Medicare and Medicaid programs or other government healthcare programs. The False Claims Act prohibits knowingly submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. The Anti- Kickback Statute prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of business under Medicare or other governmental health program. The Stark Law prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services to any entity with which the physician, or an immediate family member of the physician, has a financial relationship, unless the financial relationship fits within a permissible exception. Many states also have enacted laws similar in scope and purpose to the Anti- Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive. We believe that our operations comply with the Anti- Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows. State Regulation of our Products and Services Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance- related services regulate our operations including: capital adequacy and other licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re- entry into a state or market, rate increases, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance- related products we offer are sold under licenses issued by the applicable insurance regulators. Our licensed insurance subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and / or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports. Certain of our healthcare services businesses require a Certificate of Need, or CON, to operate in certain states. These states restrict the entry of new providers or services and the expansion of existing providers or services in their state through a CON process, which is periodically evaluated and updated as required by applicable state law. To the extent that we require a CON or other similar approvals to expand our operations, our expansion could be adversely affected by our inability to obtain the necessary approval. To the extent laws in these CON states change, including the elimination of the CON requirement, the intangible value associated with these CONs may be impaired. Any failure by us to manage acquisitions, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows. As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post- closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our transactions may cause asset write- offs, restructuring costs or other expenses and may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives, and we may divest or wind down such businesses. There can be no assurance that we will be able to complete any such divestiture on terms favorable to us, and the divestiture of certain businesses could result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations. If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business may be adversely affected. We employ or contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. A key component of our integrated care delivery strategy is to increase the number of providers who share medical cost risk with us or have financial incentives to deliver quality medical services in a cost- effective manner. In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician / hospital organizations, or multi- specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate

unfavorable contracts with us or place us at a competitive disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost- effective manner, our ability to market products or to be profitable in those areas may be adversely affected. In some situations, we have contracts with individual or groups of primary care providers for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. This type of contract is referred to as a " capitation " contract. The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows. The success of our healthcare services businesses depends on our ability, and the ability of our affiliated physician- owned professional groups and management services organizations, to recruit, hire, acquire, contract with, and retain physicians, nurses and other medical professionals who are experienced in providing care services to older adults. The market to acquire or manage physician practices, and to employ or contract with individual physicians, nurses and other medical professionals is, and is expected to remain, highly competitive, and the performance of our healthcare services businesses may be adversely impacted if we, and our affiliated physician- owned professional groups and management services organizations, are unable to attract, maintain satisfactory relationships with, and retain physicians, nurses and other medical professionals, or if these businesses are unable to retain patients following the departure of a physician, nurses or other medical professional. In addition, our healthcare services businesses contract with competitors of our health benefits businesses, and these businesses could ~~suffer~~ **be materially impacted** if they are unable to maintain relationships with these companies, or fail to adequately ~~price~~ **negotiate the terms of** their contracts with these **third- party payers, including the price and other terms of fixed fee (or capitated) agreements under which our primary care business assumes the risk that the actual cost of a basket of services provided to a patient exceeds the reimbursement provided by the health plan** third- party payers. We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our businesses, operating results and / or future performance. Our success depends on our ability to attract, develop and retain qualified employees and executives, including those with diverse backgrounds, experiences and skill sets, to operate and expand our business. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. In addition, while we have development and succession plans in place for our key employees and executives, these plans do not guarantee the services of our key employees and executives will continue to be available to us. If we are unable to attract, develop, retain and effectively manage the development and succession plans for key employees and executives, our business, results of operations and future performance could be adversely affected. Our pharmacy business is highly competitive and subjects us to regulations and distribution and supply chain risks in addition to those we face with our core health benefits businesses. Our in- house dispensing pharmacy business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail- order and long- term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out- of- state mail- order pharmacies to register with that state' s board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U. S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of prescription drugs. The Federal Trade Commission also has requirements for mail- order sellers of goods. The U. S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail- order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery could be significantly more expensive. The U. S. Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business. We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, including the application of state laws and regulations related to the operation of internet and mail- order pharmacies, violations of which could expose us to civil and criminal penalties, and manufacturing, distribution or other supply chain disruptions (including disruptions that occur as a result of catastrophes, including acts of terrorism, public health emergencies, epidemics or pandemics (such as ~~the spread of~~ COVID- 19), or natural disasters (such as hurricanes and earthquakes) which could occur more frequently or with more intense effects as a result of the impacts of global climate change), each of which could impact the availability or cost of supplying of such products. Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance. Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as " AWP, " average selling price, which is referred to as " ASP, " and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it has previously been calculated, or whether other pricing

benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our in- house dispensing pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows. Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations. Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity' s level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Dividends from our non-insurance companies such as in our CenterWell segment are generally not restricted by Departments of Insurance. In the event that we are unable to provide sufficient capital to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected. Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition. Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency' s opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such. We believe that certain of our customers place importance on our claims paying ability, financial strength, and debt ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings impact our ability to obtain future borrowings and investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected. ~~The~~ **Volatility or disruption in the** securities and credit markets **, including changes in interest rates,** may **significantly** ~~experience volatility~~ and ~~disruption, which may~~ adversely affect **the value of** our ~~business~~ **investment portfolio and the investment income that we derive from this portfolio** . Ongoing volatility or disruption in the securities and credit markets ~~could impact~~ **, including changes in interest rates, may significantly and adversely affect the value of** our **significant** investment **portfolio and the investment income that we derive from this** portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell or are not required to sell a security in an unrealized loss position, potential credit related impairments are considered using a variety of factors, including the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that declines in fair value may occur and additional material realized losses from sales or credit related impairments may be recorded in future periods. We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, ~~including the heightened uncertainty created by the COVID- 19 pandemic,~~ we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement. Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the possibility that customers or lenders could develop a negative perception of our long or short- term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all. ~~The spread of, and response to, COVID- 19 underscores certain risks we face, including those discussed above, and the ongoing, heightened uncertainty created~~

by the pandemic precludes any prediction as to the ultimate adverse impact to us of COVID- 19. COVID- 19 underscores certain risks we face, including those discussed above. As the COVID- 19 pandemic continues, the premiums we charge may prove to be insufficient to cover the cost of health care services delivered to our members, each of which could be impacted by many factors, including the impacts that we have experienced, and may continue to experience, to our revenues due to limitations on our ability to implement clinical initiatives to manage health care costs and chronic conditions of our members, and appropriately document their risk profiles, as a result of our members being unable or unwilling to see their providers due to actions taken to mitigate the spread of COVID- 19; increased costs that may result from higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs; and shifts in our premium and medical claims cost trends to reflect the demographic impact of higher mortality during the COVID- 19 pandemic. In addition, we are offering, and have been mandated by legislative and regulatory action (including the Families First Act and CARES Act) to provide, certain expanded benefit coverage to our members, such as waiving, or reimbursing, certain costs for COVID- 19 testing, vaccinations and treatment. These measures taken by us, or governmental action, to respond to the ongoing impact of COVID- 19 (including further expansion or modification of the services delivered to our members, the adoption or modification of regulatory requirements associated with those services and the costs and challenges associated with ensuring timely compliance with such requirements), and the potential for widespread testing, treatments and the distribution and administration of COVID- 19 vaccines, could adversely impact our profitability. The spread and impact of COVID- 19 and additional variants, or actions taken to mitigate this spread, could have material and adverse effects on our ability to operate effectively, including as a result of the complete or partial closure of facilities or labor shortages. Disruptions in public and private infrastructure, including communications, availability of in- person sales and marketing channels, financial services and supply chains, could materially and adversely disrupt our normal business operations. A significant subset of our and our third party providers' employee populations are in a remote work environment in an effort to mitigate the spread of COVID- 19, which may exacerbate certain risks to our business, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, and increased risk of unauthorized dissemination of sensitive personal, or proprietary and / or confidential information. The continued COVID- 19 pandemic has severely impacted global economic activity, including the businesses of some of our commercial customers, and caused significant volatility and negative pressure in the financial markets. In addition to disrupting our operations, these developments may adversely affect the timing of commercial customer premium collections and corresponding claim payments, the value of our investment portfolio, or future liquidity needs. The ongoing, heightened uncertainty created by the pandemic precludes any prediction as to the ultimate adverse impact to us of COVID- 19. We are continuing to monitor the spread of COVID- 19, changes to our benefit coverages, and the ongoing costs and business impacts of dealing with COVID- 19, including the potential costs and impacts associated with lifting, or reimposing, restrictions on movement and economic activity, the timing and degree in resumption of demand for deferred healthcare services, the pace of administration of COVID- 19 vaccines and the effectiveness of those vaccines, and related risks. The magnitude and duration of the pandemic remains uncertain, and its ultimate impact on our business, results of operations, financial position, and cash flows could be material.