Anthem, Inc.
Form 10-K
February 22, 2017
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K
(Mark One)
x 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: 001-16751
ANTHEM, INC.
(Exact name of registrant as specified in its charter)

INDIANA	35-2145715
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
120 MONUMENT CIRCLE INDIANAPOLIS, INDIANA (Address of principal executive offices)	46204 (Zip Code)

Registrant's telephone number, including area code: (317) 488-6000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, Par Value $0.01	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE
Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No ¨
Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No x
Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No ¨
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x 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. ¨
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. (Check one):
Large accelerated filer x Accelerated filer ¨
Non-accelerated filer ¨ (Do not check if a smaller reporting company Smaller reporting company ¨

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 30, 2016 was approximately $34,510,272,302.

As of February 10, 2017, 264,378,577 shares of the Registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 18, 2017.

Anthem, Inc.

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

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This Annual Report on Form 10-K, including Management's Discussion and Analysis of Financial Condition and Results of Operations, contains forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995, that reflect our views about future events and financial performance. When used in this report, the words "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan," expressions are intended to identify forward-looking statements, which are generally not historical in nature. Forward-looking statements include, but are not limited to, financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Forward-looking statements are subject to known and unknown risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various disclosures made by us, which attempt to advise interested parties of the factors that affect our business, including "Risk Factors" set forth in Part I, Item 1A hereof and our reports filed with the U.S. Securities and Exchange Commission, or SEC, from time to time. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events.

References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in the United States in terms of medical membership, serving 39.9 million medical members through our affiliated health plans as of December 31, 2016. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross (in our New York service areas). We also conduct business through arrangements with other BCBS licensees in South Carolina and Western New York. Through our AMERIGROUP Corporation, or Amerigroup, subsidiary, we conduct business in Florida, Georgia, Iowa, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, and Washington. In addition, we conduct business through our Simply Healthcare Holdings, Inc., or Simply Healthcare, subsidiary in Florida. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with Massachusetts), and in certain Arizona, California, Nevada and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

In March 2016, we filed a lawsuit against our vendor for pharmacy benefit management services, Express Scripts, Inc., or Express Scripts, seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches, and seeking various declarations under the agreement between the parties. In April 2016, Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, “Commitments and Contingencies - Litigation,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Merger Agreement, dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and our direct wholly-owned subsidiary, pursuant to which we will acquire all outstanding shares of Cigna, or the Acquisition. This Acquisition will further our goal of creating a premier health benefits company with critical diversification and scale to lead the transformation of health care delivery for consumers. Cigna is a global health services organization that delivers affordable and personalized products and services to customers through employer-based, government-sponsored and individual coverage arrangements. All of Cigna's products and services are provided exclusively by or through its operating subsidiaries, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products including group life, accident and disability insurance. Cigna maintains sales capability in 30 countries and jurisdictions.

Under the terms of the Merger Agreement, Cigna’s shareholders will receive $103.40 in cash and 0.5152 shares of our common stock for each Cigna common share outstanding. The value of the transaction is estimated to be approximately $53.0 billion based on the closing price of our common stock on the New York Stock Exchange on July 23, 2015. The final purchase price will be determined based on our closing stock price on the date of closing of the Acquisition. The combined company will reflect a pro forma equity ownership comprised of approximately 67% Anthem shareholders and approximately 33% Cigna shareholders. We expect to finance the cash portion of the Acquisition through available cash on hand and the issuance of new debt. The Acquisition is subject to certain state regulatory approvals, other standard closing conditions and customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act. For additional information, see "Risk Factors" included in Part I, Item 1A; "Management's Discussion and Analysis of Financial Condition and Results of Operations - Overview" included in

Part II, Item 7; and Note 3, “Business Acquisitions and Divestiture - Pending Acquisition of Cigna Corporation" included in Part II, Item 8 of this Annual Report on Form 10-K.

In July 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia, or District Court, seeking to block the Acquisition. Trial commenced in November 2016 and concluded in January 2017. On January 18, 2017, we provided notice to Cigna that we had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On February 8, 2017, the District Court ruled in favor of the DOJ, and following our motion to expedite the appeal, which was granted on February 17, 2017, we promptly appealed the District Court's ruling to the U.S. Circuit Court of Appeals for the District of Columbia Circuit, or the Appellate Court. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against us in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. We believe Cigna’s allegations are without merit. Also on February 14, 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted our motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. A hearing will be scheduled the week of April 10, 2017. We intend to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remain committed to completing the Acquisition as soon as practicable. If the Merger Agreement is terminated because the required regulatory approvals cannot be obtained, under certain conditions, we could be obligated to pay a $1.85 billion termination fee to Cigna.

Our vision is to become America's valued health partner. Together we are transforming health care with trusted and caring solutions and as a result, we focus on delivering quality products and services that give members access to the care they need. With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

•Accountable
•Caring
•Easy to do business with
•Innovative
•Trustworthy

We offer a broad spectrum of network-based managed care plans to large and small employer, individual, Medicaid and Medicare markets. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service, or POS, plans; traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care. We also provide services to the federal government in connection with the Federal Employee Program, or FEP.

The increased focus on health care costs by employers, the government and consumers has continued to drive the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans, such as POS plans and CDHPs, are among the various forms of managed care products that have been developed. Through these types of products, insurers attempt to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver high quality health care to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the health care system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and

generally pay co-payments, coinsurance and/or deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO, POS and CDHP

products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization, but often offer more generous benefit coverage. An HMO plan may also require members to select one of the network primary care physicians, or PCPs, to coordinate their care and approve any specialist or other services.

Economic factors, greater consumer and employer sophistication and accountability have resulted in an increased demand for choice in both product/benefit designs and provider network configurations. As a result we continue to offer our broad access PPO networks with multiple benefit designs, but are also focused on leveraging our provider collaboration initiatives with our Accountable Care Organization, or ACO, partnerships to develop both narrow and tiered network offerings. This array of network and product configurations allows both the employer and the employee to design and select the combination of benefit designs (e.g., traditional PPOs, high deductibles, HRAs, HSAs, PCP based products, tiered copays) and networks (e.g., broad, narrow, tiered, closed or exclusive provider, and open) that optimize choice, quality and price at the consumer, employer and market level. We believe we are well-positioned in each of our states to respond to these market preferences.

For our fully-insured products, we charge a premium and assume all of the health care risk. Under self-funded products, we charge a fee for services and the employer or plan sponsor reimburses us for the health care costs. In addition, we charge a premium to underwrite stop loss insurance for Large Group and National Account employers that maintain self-funded health plans.

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP.

BCBS-branded business generally refers to members in our service areas licensed by the BCBSA.

Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup, CareMore and Simply Healthcare plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, federal employee health and benefit programs, national employers and state-run programs servicing low-income, high-risk and under-served markets. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers' unique needs.

We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer on-exchange products through state or federally facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal premium subsidies are available for certain members, subject to income and family size, who purchase public exchange products.

Being a licensee of the BCBS association of companies, of which there were 36 independent primary licensees as of December 31, 2016, provides significant market value, especially when competing for very large multi-state employer groups. For example, each BCBS member company is able to utilize other BCBS licensees' substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard® and is a source of revenue when we provide member services in the states where we are the BCBS licensee to individuals who are customers of BCBS plans not affiliated with us. This program also provides a national provider network for our members when they travel to other states.

For additional information describing each of our customer types, detailed marketing efforts and changes in medical membership over the last three years, see "Management's Discussion and Analysis of Financial Condition and Results

of Operations" included in Part II, Item 7 of this Annual Report on Form 10-K.

Our results of operations depend in large part on accurately predicting health care costs and our ability to manage future health care costs through adequate product pricing, medical management, product design and negotiation of favorable provider contracts.

Advances in medical technology, increases in specialty drug costs, increases in hospital expenditures and other provider costs, the aging of the population and other demographic characteristics continue to contribute to rising health care costs. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of our innovative medical management services, quality initiatives and financial incentives. Our significant market share and high business retention rates enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. In addition, our ability to manage selling, general and administrative costs continues to be a driver of our overall profitability.

The future results of our operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, became law, causing significant changes to the U.S. health care system. Since then, significant regulations have been enacted by the U.S. Department of Health and Human Services, or HHS, the Department of Labor and the Department of the Treasury. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States, the continuing modification and interpretation of Health Care Reform rules and the potential for significant future changes to the law, we continue to analyze and refine our estimates of the ultimate impact of Health Care Reform on our business, cash flows, financial condition and results of operations. Health Care Reform presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business are likely to continue for the next several years as elected officials at the national and state level have proposed significant modification to existing laws and regulations, including the potential repeal or replacement of Health Care Reform. For additional discussion, see “Regulation,” herein and Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

In addition to the external forces discussed in the preceding paragraph, our results of operations are impacted by levels and mix of membership. In recent years, we have experienced membership growth due to the quality and pricing of our health benefits products and services, improved economic conditions, decreases in unemployment, acquisitions, entry into new markets and expansions in existing markets. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. However, these membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. See Part I, Item 1A “Risk Factors” and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in this Annual Report on Form 10-K.

Private exchanges have gained visibility in the marketplace based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, in more recent years the Commercial market has received an increased level of attention from the consulting and broker communities as well as health insurance carriers. In response, we have continued our broad-based strategy of offering Anthem Health Marketplace's consumer experience platform to groups, while also participating in four large national consultant-led exchanges, several regional broker-led exchanges and various Individual, Commercial and Medicare exchanges. To date, adoption levels in the Commercial market overall have been lower than analyst predictions. While the ultimate volume, pace of growth and winning business models remain highly uncertain in this space, we continue

to believe we are well positioned to adapt with the market as it evolves.

We believe health care is local and that we have the strong local presence required to understand and meet local customer needs. Further, we believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and health care professionals. Ultimately, we believe that practical and sustainable improvements in health care must focus on improving health care quality while managing costs for total affordability. We have implemented initiatives driving payment innovation and partnering with providers to compel improved cost, quality and health, and we continue to develop new and innovative ways to effectively manage risk and engage our members. In addition, we are focused on achieving efficiencies from our national scale while optimizing service performance for our customers. Finally, we expect to continue to rationalize our portfolio of businesses and products and align our investments to capitalize on new opportunities to drive growth in our existing markets and expand into new markets in the future.

We continue to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through web-enabled technology and improving internal operations. Our approach includes not only sales and distribution of health benefits products on the Internet, but also implementing advanced capabilities that improve services benefiting customers, agents, brokers, and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of health care through increased communications between patients and their physicians.

In pursuing our vision of becoming America's valued health partner, we intend to transform health care by providing trusted and caring solutions and delivering quality products and services that give customers access to the care they need. At the same time, we will focus on earnings per share, or EPS, growth through organic membership growth, improvements in our operating cost structure, strategic acquisitions and the efficient use of capital.

Significant Transactions

While Health Care Reform has caused significant changes to the U.S. health care system in recent years, the significant transactions that have occurred over the last five years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Pending acquisition of Cigna;
- Acquisition of Simply Healthcare (2015);
- Use of Capital—Board of Directors declaration of dividends on common stock (2012 through February 2017); authorization for repurchases of our common stock (2017 and prior); and debt repurchases and new debt issuance (2015 and prior);
- Acquisition of Amerigroup and the related debt issuance (2012); and
- Acquisition of 1-800 CONTACTS (2012) and subsequent divestiture (2014).

For additional information regarding certain of these transactions, see Note 3, “Business Acquisitions and Divestiture,” Note 12, “Debt,” and Note 14, “Capital Stock,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing and pricing, business consolidations, new competitors in the market, a proliferation of new products, the impact of Health Care Reform, and increased quality awareness and price sensitivity among customers.

We believe that participants in the managed care industry compete for customers based on quality of service, price, access to provider networks, access to care management and wellness programs (including health information), innovation, breadth and flexibility of products and benefits, reputation (including National Committee on Quality Assurance, or NCQA, accreditation status), brand recognition and financial stability. Our ability to attract and retain customers is substantially tied to our ability to distinguish ourselves from our competitors in these areas.

Also, a health plan's ability to interact with employers, customers and other third parties (including health care professionals) via the Internet has become a more important competitive factor, and we have made significant investments in technology to enhance our electronic interaction with providers, employers, customers and third parties.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with greater brand recognition over competitive product offerings. Our provider networks in our markets enable us to achieve efficiencies and distinctive service levels enabling us to offer a broad range of health benefits to our customers on a more cost-effective basis than many of our competitors. We strive to distinguish our products through provider access, service, care management, product value and brand recognition.

Pricing in our Commercial and Specialty Business segment (defined below), including our Individual and Small Group lines of business, remains competitive and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform and any subsequent changes to the current regulatory scheme. We believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider customer volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to recommend and distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that the quality and price of our products, support services, reputation and prior relationships, along with a reasonable commission structure are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to those of our competitors in all of our markets. Typically, we are the largest competitor in each of our Blue-branded markets and, thus, are a closely watched target by other insurance competitors.

Reportable Segments

We manage our operations through three reportable segments: Commercial and Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. As a result, these reportable segments may change in the future.

Our Commercial and Specialty Business and Government Business segments both offer a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans, as well as a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid; Temporary Assistance for Needy Family programs, or TANF; programs for seniors and people with disabilities, or SPD; programs for long-term services and support, or LTSS;

Children's Health Insurance Programs, or CHIP; and ACA-related Medicaid expansion programs. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes other businesses that do not individually meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Through our participation in various federal government programs, we generated approximately 18.2%, 18.8% and 21.0% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2016, 2015 and 2014, respectively. These revenues are contained in the Government Business segment. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S.

For additional information regarding the operating results of our segments, see Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Products and Services

A general description of our products and services is provided below:

Preferred Provider Organization: PPO products offer the member an option to select any health care provider, with benefits reimbursed by us at a higher level when care is received from a participating network provider. Increasingly, customers are choosing our PPO products offered with an exclusive provider organization which eliminates coverage out of network. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Consumer-Driven Health Plans: CDHPs provide consumers with increased financial responsibility, choice and control regarding how their health care dollars are spent. Generally, CDHPs combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee. Some or all of the dollars remaining in the personal care account at year-end can be rolled over to the next year for future health care needs.

Traditional Indemnity: Indemnity products offer the member an option to select any health care provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Health Maintenance Organization: HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers. A member in one of our HMOs must typically select a PCP from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary health care services. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service: POS products blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expenses (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

ACA Public Exchange and Off-Exchange Products: The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products offered on and off the public exchanges meet the definition of the "metal" product requirements (bronze, silver, gold and platinum) and each metal product must satisfy a specific actuarial value. Health insurers participating on the public exchanges must offer at least one silver and one gold product.

In our Individual markets we offer bronze, silver and gold products, both on and off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the public exchanges, in California and New York.

In our Small Group markets, we offer bronze, silver and gold products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. We offer platinum products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, New York, Virginia and Wisconsin. We offer bronze, silver and gold products, on the public exchanges, in Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio and Virginia. Additionally, we offer platinum products on the public exchange in Connecticut.

Administrative Services: In addition to fully-insured products, we provide administrative services to Large Group employers that maintain self-funded health plans. These administrative services include underwriting, actuarial services, medical cost management, disease management, wellness programs, claims processing and other administrative services for self-funded employers. Self-funded health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also underwrite stop loss insurance for self-funded plans.

BlueCard®: BlueCard® is a national program that links participating health care providers and independent BCBS plans. BlueCard® host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer sponsored health plan serviced by a non-Anthem controlled BCBS licensee, which is the “home” plan. We perform certain administrative functions for BlueCard® host members, for which we receive administrative fees from the BlueCard® members’ home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicare Plans: We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare supplement plans; Medicare Advantage, including special needs plans; Medicare Part D Prescription Drug Plans, or Medicare Part D; and Medicare-Medicaid Plans, or MMPs. Medicare supplement plans typically pay the difference between health care costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage special needs plans provide tailored benefits to Medicare beneficiaries who have chronic diseases and also cover certain dual eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare, which was established as a result of the passage of the ACA. We offer these plans to customers through our health benefit subsidiaries throughout the country, including Amerigroup, CareMore and Simply Healthcare.

Individual Plans: We offer a full range of health insurance plans with a variety of options and deductibles for individuals who are not covered by employer-sponsored coverage and are not eligible for government sponsored plans, such as Medicare and/or Medicaid. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration. Some of our products target certain demographic populations such as uninsured younger individuals between the ages of 19 and 29, families, those transitioning between jobs or early retirees.

Medicaid Plans and Other State-Sponsored Programs: We have contracts to serve members enrolled in publicly funded health care programs, including Medicaid, TANF, SPD, LTSS, CHIP, and ACA-related Medicaid expansion programs. The Medicaid program makes federal matching funds available to all states for the delivery of health care benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. TANF is a state and federally funded program designed for the population consisting primarily of low-income children and their guardians. SPD is a federal income supplement program designed for Supplemental Security Income recipients; however, states can broaden eligibility criteria. This population consists of low-income seniors and people with disabilities. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term services and support

for our members who receive home and community- or institution-based services for long-term care. CHIP is a state and federally funded program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. Our Medicaid plans also cover certain dual eligible customers, as previously described above, who also receive Medicare benefits. We provide Medicaid and other State-

Sponsored services in California, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia and Wisconsin.

Pharmacy Products: We market and sell an integrated prescription drug product to both fully-insured and self-funded customers through our health benefit subsidiaries throughout the country. This comprehensive product includes features such as drug formularies, a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Since December 1, 2009, we have delegated certain functions and administrative services related to our integrated prescription drug products to Express Scripts under a ten year contract, excluding our CareMore subsidiary and certain self-insured members who have exclusive agreements with different pharmacy benefit management, or PBM, service providers. Express Scripts manages the network of pharmacy providers, operates mail order pharmacies and processes prescription drug claims on our behalf, while we sell and support the product for clients, make formulary decisions and set drug benefit design strategy and provide front line member support. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing. For additional information, see Note 13, “Commitments and Contingencies - Litigation,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Life Insurance: We offer an array of competitive individual and group life insurance benefit products to both Large Group and Small Group customers in conjunction with our health plans. The life products include term life and accidental death and dismemberment.

Disability: We offer short-term and long-term disability products, usually in conjunction with our health plans.

Radiology Benefit Management: We offer outpatient diagnostic imaging management services to health plans. These services include utilization management for advanced diagnostic imaging procedures, network development and optimization, patient safety, claims adjudication and provider payment.

Personal Health Care Guidance: We offer evidence-based and analytics-driven personal health care guidance. These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs.

Dental: Our dental plans include networks in certain states in which we operate. Many of the dental benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans. The National Dental GRID includes dentists in all 50 states and provides multi-state customers with a national solution providing in-network discounts across the country. Additionally, we offer managed dental services to other health care plans to assist those plans in providing dental benefits to their customers.

Vision Services and Products: Our vision plans include networks within the states in which we operate. Many of the vision benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis.

Medicare Administrative Operations: Through our subsidiary, NGS, we serve as a fiscal intermediary, carrier and Medicare administrative contractor for the federal government providing administrative services for the Medicare program, which generally provides coverage for persons who are 65 or older and for persons who are disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other health care facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render health care services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While following industry standards, we are simultaneously seeking to lead transformation efforts within our health care system, moving from our current fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the needs of the patient. A key element of this transformation involves a transition from traditional fee-for-

service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver.

We establish “market-based” hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In many instances, we deploy multi-year contracting strategies, including case rates or fixed rates, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad-based networks with smaller or more cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers.

Our reimbursement strategies vary across markets and depend on the degree of consolidation and integration of physician groups and hospitals. Fee-for-service is currently our predominant reimbursement methodology for physicians, but as noted above, we are transitioning providers to value-based payment contracts. More traditional physician fee schedules are developed at the state level based on an assessment of several factors and conditions, including the Centers for Medicare & Medicaid Services, or CMS, resource-based relative value system, or RBRVS, medical practice cost inflation and physician supply. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed, maintained, and updated by CMS and is used by the Medicare program and other major payers. In addition, we have implemented and continue to expand physician incentive contracting, or “pay for performance,” which ties physician payment levels to performance on clinical measures.

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, we maintain capitation-based arrangements in certain markets where we determine that market dynamics result in it being a useful method to lower costs and reduce underwriting risk.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our “per-case” reimbursement methods utilize many of the same attributes contained in Medicare’s Diagnosis Related Groups, or DRG, methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a “pay for performance” component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Although fee-for-service combined with pay for performance remains our predominant payment model today, our provider engagement and contracting strategies are moving away from “unit price” or volume-based payment models to payment models that align compensation with the value delivered as measured by health care, quality and cost. We launched the most significant of these efforts, our Enhanced Personal Health Care program, in the fourth quarter of 2012. This program augments traditional fee-for-service with shared savings opportunities for providers when actual health care costs are below projected costs, and providers meet specific quality measures. The quality measures are based on nationally accepted, credible standards (e.g. NCQA, the American Diabetes Association and the American Academy of Pediatrics) and span preventive, acute and chronic care. We understand, however, that payment incentives alone are insufficient to create the large-scale, system-wide transformation required to achieve meaningful impacts on cost, quality and member experience. Accordingly, we invested in care delivery transformation and population health management support structures to help providers succeed under value-based payment models. This support includes our web-based population health management technology and teams of dedicated expert consultants who work alongside providers, sharing best practices, and helping them leverage our data to the benefit of their patients. In some of these arrangements, participating physician practices receive a per-member, per-month clinical coordination fee to compensate them for important care management activities that occur outside of the patient visit (e.g. purchasing an electronic health record or hiring care management nurses), all of which have been shown to

reduce healthcare costs and improve care outcomes. Since the launch of Enhanced Personal Health Care, we now have arrangements with provider organizations covering 51% of our PCPs and have rolled this program out in each of the fourteen states where we operate as a licensee of the BCBSA.

Medical Management Programs

Our medical management programs include a broad array of activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and nurses. The goals of our medical management strategies are to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate location. The following is a general description of our medical management programs, which are available to our members depending on the particular plan or product in which they participate:

Precertification: A traditional medical management program involves assessment of the appropriateness of certain hospitalizations and other medical services prior to the services being rendered. For example, precertification is used to determine whether a set of hospital and medical services is being appropriately applied to the member's clinical condition, in accordance with criteria for medical necessity as that term is defined in the member's benefits contract. All of our health plans have implemented precertification programs for common high-tech radiology studies, including cardiac diagnostic testing, addressing an area of historically significant cost trends. Through our AIM Specialty Health, or AIM, subsidiary we promote appropriate, safe and affordable member care in imaging as well as oncology, sleep management and specialty pharmacy benefits. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage our provider communities and members in more effective and efficient use of outpatient services.

Care Coordination: Another traditional medical management strategy we use is care coordination, which is based on nationally recognized criteria developed by third-party medical specialists. With inpatient care coordination, the requirements and intensity of services during a patient's hospital stay are reviewed, at times by an onsite skilled nurse professional in collaboration with the hospital's medical and nursing staff, in order to coordinate care and determine the most effective transition of care from the hospital setting. In addition, guidance for many continued stay cases is reviewed with physician medical directors to ensure appropriate utilization of medical services. We also coordinate care for outpatient services to help ensure that patients with chronic conditions who receive care from multiple physicians are able to manage the exchange of information between physicians and coordinate office visits to their physicians.

Case Management: We have implemented a medical management strategy focused on identifying the small percentage of the membership that will require a high level of intervention to manage their health care needs. The registered nurses and medical directors focus on members likely to be readmitted to the hospital and help them coordinate their care through pharmacy compliance, post-hospital care, follow-up visits to see their physician and support in their home. We are also working to move increasing aspects of this work to the providers we work with via our provider collaboration programs such as Togetherworks, a set of capabilities, offerings, programs and products that help us partner with providers to leverage data, insights and technology to deliver the right care, at the right time, in the right place.

Formulary management: We have developed formularies, which are selections of drugs based on clinical quality and effectiveness. A pharmacy and therapeutics committee of physicians uses scientific and clinical evidence to ensure that our members have access to the appropriate drug therapies.

Medical policy: A medical policy group, comprised of physician leaders from various areas of the country, working in cooperation with academic medical centers, practicing community physicians and medical specialty organizations such as the American College of Radiology and national organizations such as the Centers for Disease Control and Prevention and the American Cancer Society, determines our national policy for the application of new medical technologies and treatments.

Quality programs: We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incentivize hospitals and physicians to support national initiatives to improve the quality of clinical care and patient outcomes and to reduce medication errors and hospital infections.

External review procedures: We work with outside experts through a process of external review to provide our members scientifically and clinically, evidence-based medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes related to medical necessity decisions under the

benefits contract to be settled by independent expert physicians.

Service management: In HMO and POS networks, PCPs serve as the overall coordinators of members' health care needs by providing an array of preventive health services and overseeing referrals to specialists for appropriate medical care. In PPO networks, patients have access to network physicians without a PCP serving as the coordinator of care.

Provider Cost Comparison Tools: Through Estimate Your Cost, Anthem Care Comparison and other tools, our members can compare cost estimates and quality data for common services at contracted providers, with cost estimates accounting for facility, professional and ancillary services. These cost estimates bundle related services typically performed at the time of the procedure, not just for the procedure itself. Users can review cost data for over 400 procedures in 49 states. Members can also estimate out-of-pocket costs based on a member's own benefit coverage, deductible, and out of pocket maximum. We also offer information on overall facility ratings and patient experience using trusted third party data. We continue to work on enhancing and evolving our tools to assist members in making informed and value-based health care decisions. In addition, we collaborate with an external independent vendor to support employers wanting to purchase a transparency and consumer engagement web solution with certain additional functionality.

Personal Health Care Guidance: These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs. Examples of services include member and physician messaging, providing access to evidence-based medical guidelines, physician quality profiling, and other consulting services.

Anthem Health Guide: Anthem Health Guide integrates customer service with clinical and wellness coaching to provide easier navigation of health care services for our members. Members are supported by a team of nurses, coaches, educators, and social workers using voice, click-to-chat, secure email and mobile technology. Our Smart Engagement Platform supports this integrated team using our smart engagement triggers for speech recognition, preventative and clinical gaps in care and highlighting when we have members who are identified for current health care support.

Care Management Programs

We continue to expand our 360º Health suite of integrated care management programs and tools. 360º Health offers the following programs, among others, which are available to our members depending on the particular plan or product in which they participate, and have been proven to increase quality and reduce medical costs for our members:

ConditionCare and FutureMoms are care management and maternity management programs that serve as adjuncts to physician care. Skilled nurse professionals with added support from our team of dietitians, social workers, pharmacists, health educators and other health professionals help participants understand their condition, their doctor's orders and how to become a better self-manager of their condition. We also offer members infertility consultation through our SpecialOffers@Anthem program, a comprehensive and integrated assembly of discounted health and wellness products and services from a variety of the nation's leading retailers.

24/7 NurseLine offers access to qualified, registered nurses anytime. This allows our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. This program also includes a referral process to the nearest urgent care facility, a robust audio library, accessible by phone, with more than 600 health and wellness topics, as well as on-line health education topics designed to educate members about symptoms and treatment of many common health concerns.

ComplexCase Management is an advanced care management program that reaches out to participants with multiple health care issues who are at risk for frequent and high levels of medical care in order to offer support and assistance in managing their health care needs. ComplexCase Management identifies candidates through claims analysis using predictive modeling techniques, the use of health risk assessment data, utilization management reports and referrals from a physician or one of our other programs, such as the 24/7 NurseLine.

MyHealth Advantage utilizes integrated information systems and sophisticated data analytics to help our members improve their compliance with evidence-based care guidelines, providing personal care notes that alert members to potential gaps in care, enable more prudent health care choices, and assist in the realization of member out-of-pocket cost savings. Key opportunities are also shared with physicians through Availity® at the time of membership eligibility verification. Availity® is an electronic data interchange system that allows for the exchange of health information among providers over a secure network.

MyHealth Coach provides our members with a professional guide who helps them navigate the health care system and make better decisions about their well-being. MyHealth Coach proactively reaches out to people who are at risk for potentially serious health issues or have complex health care needs. Our health coaches help participants understand and manage chronic conditions, handle any health and wellness related services they need and make smart lifestyle choices.

HealthyLifestyles helps employees transform unhealthy habits into positive ones by focusing on behaviors that can have a positive effect on their health and their employer's financial well-being. HealthyLifestyles programs include smoking cessation, weight management, stress management, physical activity, and diet and nutrition.

MyHealth@Anthem is our secure web-based solution, complementing other programs by reinforcing telephonic coaching and mail campaigns. The website engages participants in regularly assessing their health status, gives them feedback about their progress, and tracks important health measures such as blood pressure, weight and blood glucose levels.

Behavioral Health Case Management is an integrated component of the health plan, supporting a wide range of members who are impacted by their behavioral health condition including specialty areas such as eating disorders, co-morbid medical/behavioral health, minors, substance use, and maternity. The program assists members and their families with obtaining appropriate behavioral health treatment, offering community resources, providing education and telephonic support, and promoting provider collaboration.

Autism Spectrum Disorder is a specialized case management program staffed by a dedicated team of clinicians who have been trained on the unique challenges and needs of families with a member who has a diagnosis of autism spectrum disorder. These clinicians provide education, information on community resources to help with care and support, guidance on the appropriate usage of benefits, and assistance in exploring effective treatments, such as medical services, that may help the member and their families.

Employee Assistance Programs provide many resources that allow members to balance work and personal life by providing quick and easy access to confidential resources to help meet the challenges of daily life. Examples of services available in person as well as via telephone or internet are counseling for child care, health and wellness, financial issues, legal issues, adoption and daily living.

Health Care Quality Initiatives

Increasingly, the health care industry is able to define quality health care based on preventive health measurements, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to work with our network physicians and hospitals to improve the quality and outcomes of the health care services provided to our members. Our ability to promote quality medical care has been recognized by the NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality health care measures, including the Healthcare Effectiveness Data and Information Set, or HEDIS®, have been incorporated into the NCQA's accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for patients with heart disease. For health plans, NCQA's highest accreditation status of Excellent is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS® results that are in the highest range of national or regional performance. Details for each of our plans' accreditation levels can be found at www.ncqa.org.

We have created an innovative program called the State Health Index, or SHI, to quantify and track our success in improving the health of our communities. SHI presents a comprehensive picture of a community's health in the 25 states served by our affiliated health plans, and in Washington D.C. It is compiled from public data and includes 18 health indicators in five domains: Maternity and Prenatal Care, Preventive Care, Lifestyle, Disability and Behavioral Health, and Morbidity/Mortality. The metrics are utilized to identify opportunities for health improvement and leverage our strengths to collaborate with community coalitions, patient advocacy organizations, and local and state public health departments. We analyze states' performance measures and prioritize measures for focused improvement. Together with Anthem Foundation, Inc. and state leadership, we create or enhance programs to improve the health of the entire population in these states - not just for our members.

Our wholly-owned health outcomes research subsidiary, HealthCore, Inc., or HealthCore, generates consistent and actionable evidence to support decision making while helping to guide fresh initiatives for a range of stakeholders in the healthcare industry. By leveraging a rich array of medical and pharmacy utilization data queried from administrative claims, patient surveys, medical charts and laboratory diagnostics, among other health records, HealthCore's multi-disciplinary research teams uncover a broad spectrum of safety, effectiveness, pharmacoepidemiology, and health economics evidence. HealthCore's real world evidence and comparative effectiveness research, among others, have played roles in the product planning and development campaigns of biotechnology and pharmaceutical companies, and today it lists most of the leading biologics and drug manufacturers as clients or alliance partners. Its health plan research has led to better insights into evidence-based treatment approaches, the development of value-based initiatives to drive access and adherence to treatment, and the crafting of incentives to modify patient and provider behavior. One of HealthCore's predominant initiatives is its governmental and academic collaborations that include cooperation with some of the country's top universities and federal agencies, including the Food and Drug Administration and the Centers of Disease Control of the National Institutes of Health, and it is an active contributor to the safety surveillance Sentinel program. Additionally, HealthCore has taken a thought-leadership position in the development of pragmatic clinical trials. As a notable contributor to the health outcomes evidence base, HealthCore's research findings are broadly disseminated during presentations at national and international medical meetings and are published in a variety of respected peer-reviewed medical and health services journals.

Our AIM subsidiary supports quality by implementing clinical appropriateness and patient safety solutions for advanced imaging procedures, cardiology, sleep medicine, specialty pharmaceuticals and oncology, including drugs covered under medical benefit and radiation therapy. These programs, based on widely accepted and evidence based clinical guidelines, promote the most appropriate use of diagnostic and therapeutic services to improve the quality of overall health care delivered to our members and members of other health plans that are covered under AIM's programs. To provide additional impact to its clinical appropriateness program, AIM has also implemented a provider assessment program, OptiNet®, which promotes more informed selection of diagnostic imaging and testing facilities by providing cost and facility information to physician offices at the point that a procedure is ordered. We have also leveraged AIM's provider network assessment information to proactively engage and educate our members about imaging providers and sleep testing choices based on site capabilities and cost differences. This program is another example of how we facilitate improvements in the quality of care provided to our members and promote cost effective medical care.

Our wholly-owned analytics-driven subsidiary, Resolution Health, Inc., or RHI, delivers programs to improve the safety, quality and coordination of health care for our members. RHI uses evidence-based proprietary rules and algorithms based on established clinical guidelines and standards of independent accreditation organizations, medical specialty societies, and government agencies such as the National Quality Forum, or NQF, and NCQA. RHI analyzes claims and other data to identify actions that can improve health outcomes at the individual member level. When appropriate, RHI delivers personalized confidential messages, or Personalized Health Insights, to members, providers and care managers. RHI's Personalized Health Insights support total population health management and the results of RHI analyses are used across our enterprise to support HEDIS and other clinical quality measures.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current health care claim costs and emerging health care cost trends, combined with charges for administrative expenses, risk and profit, including charges for ACA taxes and fees, where applicable. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our profitability goals and strategies.

In applying our pricing to each employer group and customer, we maintain consistent, competitive, disciplined underwriting standards. We employ our proprietary accumulated actuarial and financial data in determining underwriting and pricing parameters for both our fully insured and self-funded business.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For fully-insured business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative

experience is charged against a rate stabilization fund established from the group's favorable experience, or charged against future favorable experience.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. We have no right to market products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products. We are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various operational, governance and financial standards set forth in the licenses.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K for additional details of our licensing requirements and the impact if we were not to comply with these license agreements.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. As discussed below, the regulatory aspects of the U.S. health care system have been and will continue to be significantly affected by Health Care Reform and subsequent legislative and regulatory changes at the federal and state levels. Supervisory agencies, including state health, insurance and corporation departments, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate our products and services in great detail;
- regulate, limit, or suspend our ability to market products, including the exclusion of our plans from participating on public exchanges;
- retroactively adjust premium rates;
- monitor our solvency and reserve adequacy;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

To carry out these tasks, these regulators periodically examine our operations and accounts.

Regulation of Insurance Company and HMO Business Activity

The governments of the states in which we conduct business, as well as the federal government, have adopted laws and regulations that govern our business activities in various ways. Further, Health Care Reform has resulted in increased federal regulation that significantly impacts our business. These laws and regulations, which vary significantly from state to state, restrict how we conduct our businesses and result in additional burdens and costs to us. These federal and state laws and regulations are subject to amendments and changing interpretations in each jurisdiction.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. If we were to establish a health insurance company or an HMO in any jurisdiction, we generally would have to obtain such a certificate or authorization to expand the operations permitted under an existing certificate if we already operate in the state. The time necessary to obtain such a certificate varies from jurisdiction to jurisdiction. 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. The health benefits business also may be adversely impacted by court and regulatory decisions that expand the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs

caused by potential legislation, regulation or court rulings. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

Patient Protection and Affordable Care Act

The ACA significantly changed health insurance markets by prohibiting lifetime limits, certain annual limits, member cost-sharing on specified preventive benefits and pre-existing condition exclusions. Further, the ACA implemented certain requirements for insurers including changes to Medicare Advantage payments and the minimum medical loss ratio, or MLR, provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. In addition, the ACA also required a number of other changes with significant effects on both federal and state health insurance markets, including strict rules on how health insurance is rated, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of public exchanges for Individuals and Small Groups, the availability of premium subsidies for certain Individual products, and substantial expansions in eligibility for Medicaid. As a number of elected officials at both the national and state level have proposed significant modification, repeal or replacement of Health Care Reform, changes to the health care system are expected which could have far-reaching consequences for our business.

Despite significant preparation for the advent of the public exchanges, there have been many technical difficulties in their implementation, which entail uncertainties associated with mix and volume of business. In addition, CMS issued transitional policies modifying or extending the deadlines for compliance with certain aspects of Health Care Reform. In February 2016, CMS issued transition relief providing that health insurance coverage in the Individual or Small Group markets that is renewed for a policy year beginning on or before October 1, 2017 that would otherwise have been deemed non-compliant with certain market reforms under Health Care Reform, will not be considered by CMS to be out of compliance with respect to such market reforms, provided certain conditions are met and that all such policies end by December 31, 2017. Some states have adopted these transitional policies, some have not and others have not taken a position.

In general, individuals participating in the public exchange markets have had a higher acuity level than the pool of participants we anticipated when we established pricing. Based on our experience in public exchange markets to date, we have made adjustments to our premium rates, and we will continue to evaluate the performance of our public exchange plans going forward. In addition, the risk adjustment, reinsurance, and risk corridor premium stabilization programs of Health Care Reform, or Health Care Reform Premium Stabilization Programs, established to apportion risk amongst insurers, have faced uncertainties related to funding and payment allocations and may not be effective in appropriately mitigating the financial risks related to our public exchange products. These factors may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

In addition, there have been material changes and delays in the implementation of the ACA that could have a material adverse effect on our results of operations, financial position, and cash flows. These include:

- Network adequacy standards;
- Reduction in the amount available for payments under the risk corridor program;
- Change in Small Group size expansion;
- Increasingly complex and detailed regulation; and
- Other unanticipated regulatory changes and delays.

These delays and changes may have a material and significant impact on anticipated enrollment in public exchange and off-exchange products, thus affecting the risk pools and premium rates. Further, implementation of the ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of False Claims Act violations, and an increased risk of other litigation. Finally, the 2016 presidential and congressional election results have created additional uncertainty regarding the future of the ACA and increased the potential for substantial and potentially unforeseen changes to the law that may have a material effect on our business.

The ACA continues to require additional guidance and specificity to be provided by HHS, the Department of Labor, CMS and the Department of the Treasury. Some of the more significant rules are described below:

- The minimum MLR thresholds by line of business, as defined by HHS, are as follows:

Line of Business	%
Large Group	85
Small Group	80
Individual	80

New York state regulations require us to meet a more restrictive MLR threshold of 82% for both Small Group and Individual lines of business. The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of "benefit expense ratio" based on premium revenue and benefit expense as reported in accordance with U.S. generally accepted accounting principles, or GAAP. Furthermore, the definitions of the lines of business differ under the various federal and state regulations and may not correspond to our lines of business. Definitions under the MLR regulation also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry. Significant changes to the MLR requirements may occur through additional regulatory action by HHS.

Health Care Reform also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D plans beginning in 2014. Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

Approximately 82.1% and 34.7% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2016. Approximately 86.8% and 36.0% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2015.

- The ACA created an incentive payment program for Medicare Advantage plans. CMS developed the Medicare Advantage Star Ratings System, which awards between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in several categories, including quality of care and customer service. The star ratings are used by CMS to award quality-based bonus payments to plans that receive a rating of 4.0 or higher. The methodology and measures included in the star ratings system can be modified by CMS annually. As of December 31, 2016, all of our Medicare Advantage plans have received a rating of 3.0 or higher.

- The ACA required states to establish public exchanges through which qualified individuals and qualified small employers may access coverage. If a state failed to establish a public exchange, the federal government established a public exchange in that state. To date there are twelve state-based marketplaces, five state-based marketplaces that rely on the federal platform, and thirty four federal exchange states. In the states in which we offer products on public exchanges, six states have passed legislation or executive orders establishing state-based public exchanges (California, Colorado, Connecticut, Kentucky, Nevada and New York).

- The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products must cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products must meet the definition of the "metal" product requirements (bronze, silver, gold and platinum). Each metal product must satisfy a specific actuarial value. Health insurers participating on public exchanges must offer at least one silver and one gold product. Additionally, effective January 1, 2014, health insurers were required to cancel or discontinue the sale of existing non-ACA-compliant Individual and Small Group products, subject to the conditions of the CMS transitional policies discussed above.

- Regulations require premium rate increases to be reviewed for Small Group and Individual products above specified thresholds, generally 10%, as may be adjusted from time to time. The regulations provide for state insurance regulators to conduct the reviews, except for cases where a state does not have an "effective" rate review program or in federal enforcement states, in which cases HHS will conduct the reviews for any rate increase.
- The Health Care Reform Premium Stabilization Programs introduced new requirements to the MLR calculation, beginning with the 2014 benefit year for the Individual and Small Group markets. The risk adjustment program is a permanent program that transfers dollars from insurers who enroll individuals with lower relative health risk to insurers who enroll individuals with higher relative health risk. Risk adjustment payments/receipts will be determined separately for each state and for Individual and Small Group. The second premium stabilization program is the transitional reinsurance program, a temporary program that ran from 2014 through 2016. The transitional reinsurance program was intended to help stabilize premiums by reimbursing issuers of ACA-compliant non-grandfathered Individual market plans for eligible claims between a defined attachment point and ceiling, at a coinsurance rate defined by HHS. The program was funded through assessments per covered enrollee upon the commercial health insurance market and sponsors of self-funded health benefit plans of approximately $12.0 billion, $8.0 billion and $5.0 billion in 2014, 2015 and 2016, respectively. The reinsurance program has been under significant Congressional scrutiny. Any changes to the final settlements for the reinsurance program could have significant implications for the stability of the exchanges. The final premium stabilization program is the temporary risk corridor program, also a three year program through 2016, that was designed to protect insurers from inaccurate pricing of Individual and Small Group qualified health plans and substantially similar off-exchange products. Beginning in 2014, MLR rebate calculations are adjusted to reflect the impact of the Health Care Reform Premium Stabilization Programs.
- Prior to the implementation of the ACA, health insurers were permitted to use differential pricing, commonly referred to as "rating bands," based on factors such as health status, gender and age. The ACA precludes health insurers from using health status and gender in the determination of the insurance premium. In addition, rating bands for age cannot vary by more than 3 to 1 and rating bands for tobacco use cannot vary by more than 1.5 to 1. The ongoing use of the 3 to 1 rating bands may have a significant impact on the majority of Individual and Small Group customers and could lead to adverse selection in the market as well as increased variability in projecting future premiums for those customer markets.
- In 2014 significant new taxes and fees became effective for health insurers, some of which may or may not be passed through to customers. The most significant of the taxes and fees is the annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount due from allocations to health insurers was $11.3 billion for each of 2016 and 2015 and $8.0 billion for 2014. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee was $1.2 billion for each of 2016 and 2015 and $0.9 billion for 2014. The annual HIP Fee has been suspended for 2017 and is currently scheduled to resume and be increased to $14.3 billion for 2018, unless otherwise changed by subsequent legislative or regulatory action. For 2019 and beyond, the annual HIP Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.
- Medicare Advantage reimbursement rates will not increase as much as they would otherwise due to a new payment formula promulgated by the ACA that is expected to significantly reduce reimbursements in the future. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, evolving methodology for ratings and quality bonus payments, and potential action on an audit methodology to review data submitted under "risk adjuster" programs.

Dodd-Frank Wall Street Reform and Consumer Protection Act

The Dodd-Frank Wall Street Reform and Consumer Protection Act, or the Dodd-Frank Act, includes a number of financial reforms and regulations that affect our business and financial reporting, including margin requirements and reporting and clearing transactions for our investments in derivative instruments. In addition, the Dodd-Frank Act creates a Federal Insurance Office, with limited powers that include information-gathering and subpoena authority for certain parts of our business, including life insurance, but excluding health insurance. The 2016 presidential and congressional election results have created additional uncertainty regarding the future of the Dodd-Frank Act and increased the potential for changes to the law that may affect our business.

HIPAA and Gramm-Leach-Bliley Act

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, imposes obligations for issuers of health insurance coverage and health benefit plan sponsors. This law requires guaranteed renewability of health care coverage for most group health plans and certain individuals. Also, the law limited exclusions based on preexisting medical conditions.

The administrative simplification provisions of HIPAA imposed a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses). These requirements include uniform standards of common electronic health care transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers. Additional federal privacy and security requirements, including breach notification, improved enforcement, and additional limitations on use and disclosure of protected health information were passed through the Health Information Technology for Economic and Clinical Health, or HITECH, Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations. CMS adopted operating rules for two electronic transactions: eligibility for a health plan and health care claims status. These rules had a January 1, 2013 compliance date and we believe we have effectively complied with the requirements.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to “opt out” of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law. In addition, a number of states have adopted data security laws and/or regulations, regulating data security and/or requiring security breach notification, which may apply to us in certain circumstances.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended, or ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor. ERISA regulates certain aspects of the relationships between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

HMO and Insurance Holding Company Laws, including Risk-Based Capital Requirements

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states’ insurance departments certain reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance and general business operations. In addition, various notice and reporting requirements generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company system,

depending on the size and nature of the transactions. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled 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, which 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. Dispositions of control generally are also regulated under the state holding company acts.

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. 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. The law requires increasing degrees of regulatory oversight and intervention as a company's RBC declines. As of December 31, 2016, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC requirements.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments against insurance companies that issue policies of accident or sickness insurance are made retrospectively. Some states permit insurers to recover assessments paid through full or partial premium tax offsets or through future policyholder assessments.

While the amount and timing of any future assessments cannot be predicted with certainty, we believe that future guaranty association assessments for insurer insolvencies will not have a material adverse effect on our liquidity and capital resources with the exception of exposure related to the Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company insolvency as discussed in Note 13, "Commitments and Contingencies," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Employees

At December 31, 2016, we had approximately 53,000 employees. Our employees are an important asset, and we seek to develop them to their full potential. We believe that our relationship with our employees is good.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended, or Exchange Act) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission, or SEC. Our Internet website is www.antheminc.com. We have included our Internet website address throughout this Annual Report on Form 10-K as textual reference only. The information contained on, or accessible through, our Internet website is not incorporated into this Annual Report on Form 10-K. We make available, free of charge, by mail or through our Internet website, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our Internet website our Corporate Governance Guidelines, our Standards of Ethical Business Conduct and the charter of each standing committee of our Board

of Directors. In addition, we intend to disclose on our Internet website any amendments to, or waivers from, our Standards of Ethical Business Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange, or NYSE. Anthem, Inc. is an Indiana corporation incorporated on July 17, 2001.

ITEM 1A. RISK FACTORS.

The following is a description of significant factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time. Such factors may have a material adverse effect on our business, financial condition, and results of operations and you should carefully consider them. It is not possible to predict or identify all such factors. Consequently, you should not consider any such list to be a complete statement of all our potential risks or uncertainties. Because of these and other factors, past performance should not be considered an indication of future performance.

Health Care Reform, together with the changes in federal and state regulations that have been, and continue to be, enacted to implement it, or future changes involving the significant modification, repeal or replacement of Health Care Reform could adversely affect our business, cash flows, financial condition and results of operations.

The passage of Health Care Reform and subsequent regulations represent significant changes to the U.S. health care system. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. In addition, these laws impose significant fees, assessments and taxes on us and other health insurers, health plans and other industry participants.

Similarly, a number of elected officials at both the federal and state level have proposed substantial changes to the United States' health care system, including the significant modification, repeal or replacement of Health Care Reform, which could have far-reaching consequences for our business.

One of our most significant costs under Health Care Reform is the annual industry-wide HIP Fee. The total amount due from allocations to health insurers in 2016, 2015 and 2014 was $11.3 billion, $11.3 billion and $8.0 billion, respectively, and our portion of the HIP Fee for 2016, 2015 and 2014 was $1.2 billion, $1.2 billion and $0.9 billion, respectively. The HIP Fee has been suspended for 2017 and is currently scheduled to resume in 2018 at the increased amount of $14.3 billion, with annual adjustments thereafter. Due to the suspension of the HIP Fee for 2017, we may be unable to appropriately price 2017 renewals with policy months occurring in 2018 to appropriately include our portion of the 2018 HIP Fee. The HIP Fee is not deductible for income tax purposes and is allocated pro rata among us and other industry participants based on net premiums written. Health Care Reform also imposed industry-wide reinsurance assessments under a temporary three year program which were $5.0 billion, $8.0 billion and $12.0 billion for 2016, 2015 and 2014, respectively. The reinsurance assessments were based on a national contribution rate assessed, per covered enrollee, upon the commercial health insurance market and sponsors of self-funded health benefit plans. As we are one of the nation's largest health benefits companies, we expect our share of the Health Care Reform fees, assessments and taxes will continue to be significant. We may not be able to include or recoup all or a portion of these fees, assessments and taxes in our premium or public program rates.

Health Care Reform imposes regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum MLR and customer rebate requirements; creation of a federal rate review process; a requirement to cover preventive services on a first dollar basis; the establishment of public exchanges and essential benefit packages and greater limitations on how we price certain of our products. In addition, the legislation reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time and limits the amount of executive compensation that is deductible for income tax purposes.

The legislation also contains risk adjustment provisions applicable to the Individual and Small Group markets that effectively transfer funds from health plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to help protect against adverse selection. Effectively adapting to these risk adjustment provisions has required us to modify our operational and strategic initiatives to focus on and manage different populations of potential members than we have in the past. If we are not able to successfully design and implement operational and

strategic initiatives to adapt to these changes in

certain of our markets, our financial condition and results of operations may be adversely affected. Further, the Health Care Reform Premium Stabilization programs may not make payments timely, or as expected, due to lower than anticipated collections. For example, through 2016, the risk corridor program has fallen short of expectations and, as a result, payments from the program were approximately 14.9% of the amounts that were requested by health insurance issuers for 2014. No payments from the program have been made by HHS against the amounts owed for 2015 and 2016. Although HHS has stated that future collections under the program will be applied to shortfalls from previous years prior to making payments for subsequent years, there can be no assurance that any remaining funds due under this program will be recovered. As we have consistently done since 2014, we have continued our conservative posture of recording a 100% valuation allowance against any unpaid receivables owed to us under the risk corridor program for the 2014, 2015 and 2016 benefit years.

Although Health Care Reform has been substantially implemented, further regulations and modifications to Health Care Reform, including repeal or replacement, could have a significant impact on us through potential disruption to the employer-based market, cost shifting in the health care delivery system to insurance companies and limitations on the ability to increase premiums to meet costs. We have dedicated material resources and incurred material expenses to implement and comply with Health Care Reform at both the federal and state levels, including significant investments in new products, services and technologies, and we expect to dedicate material resources and incur material expenses going forward to implement and comply with future regulations that provide guidance and clarification on significant portions of the legislation. Health Care Reform and associated regulations are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets.

Similarly, the significant modification, repeal or replacement of Health Care Reform would likely have significant effects on our business and future operations, some of which may adversely affect our results of operations.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are subject to significant government regulation, and changes in the regulation of our business by federal and state regulators may adversely affect our business, cash flows, financial condition and results of operations.

Our business is subject to regulation at the federal and state level. In addition to Health Care Reform, we face regulation associated with many aspects of our business, including, but not limited to, licensing, premiums, marketing activities, provider contracting, access and payment standards, and corporate governance and financial reporting matters.

Our insurance, managed health care and HMO subsidiaries are subject to extensive regulation and supervision by regulatory authorities in each state in which they are licensed or authorized to do business, in addition to regulation by federal agencies. Future regulatory action by state or federal authorities could have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations. In addition, because of our participation in government-sponsored programs such as Medicare and Medicaid, a number of our subsidiaries are also subject to regulation by CMS and state Medicaid agencies, and to changes in government regulations or policy with respect to, among other things, reimbursement levels, eligibility requirements, benefit coverage requirements and additional governmental participation which could also adversely affect our business, financial condition and results of operations. In addition, changes in tax laws and regulations, or changes in the interpretation of tax laws and regulations by federal and/or state authorities may have a material adverse effect on our business, cash flows, operations or financial condition.

State legislatures will continue to focus on health care delivery and financing issues, especially given proposals for the significant modification, repeal or replacement of Health Care Reform. Such issues are sometimes addressed directly by voters in ballot initiatives, such as the recent ballot initiative in Colorado that attempted to replace health insurers in the state with a single government payer. Most states are very focused on how to manage and reduce their budgets and are exploring ways to mitigate cost increases. As such, some states have acted to reduce or limit increases to premium payments. Others have enacted, or are contemplating, significant reform of their health insurance markets to include provisions affecting both public programs and privately-financed health insurance arrangements. If enacted into law, these state proposals could have a material adverse impact on our business, cash flows, operations or

financial condition.

The existence of multiple public insurance exchange options has led to increased uncertainties and made our planning for the public exchanges more difficult as we are required to comply with the varying rules of multiple exchanges. In addition, a number of states in which we offer Medicaid products, including Florida, Georgia, Kansas, South Carolina, Tennessee, Texas, Virginia and Wisconsin, have indicated their current decision to opt out of Medicaid expansion, at least for the present time. Where states allow certain programs to expire or opt out of Medicaid expansion, we could experience reduced Medicaid enrollment and reduced growth opportunities. If future modifications to Health Care Reform significantly reduce the Medicaid expansion program, this will negatively impact our Medicaid business.

Additionally, from time to time, Congress has considered, and may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. There have been legislative attempts to limit ERISA's preemptive effect on state laws and litigants' ability to seek damages beyond the benefits offered under their plans. If adopted, such limitations could increase our liability exposure, could permit greater state regulation of our operations, and could expand the scope of damages, including punitive damages, litigants could be awarded. While we cannot predict if any of these initiatives will ultimately become effective or, if enacted, what their terms will be, their enactment could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business.

Our inability to contain health care costs, implement increases in premium rates on a timely basis, appropriately price our public exchange products, maintain adequate reserves for policy benefits or maintain cost effective provider agreements may adversely affect our business and profitability.

Our profitability depends in large part on accurately predicting health care costs and on our ability to manage future health care costs through medical management, product design, negotiation of favorable provider contracts and underwriting criteria. Government-imposed limitations on Medicare and Medicaid reimbursement have also caused the private sector to bear a greater share of increasing health care costs. Changes in health care practices, demographic characteristics, inflation, new technologies, the cost of prescription drugs, clusters of high cost cases, changes in the regulatory environment and numerous other factors affecting the cost of health care may adversely affect our ability to predict and manage health care costs, as well as our business, financial condition and results of operations.

Relatively small differences between predicted and actual health care costs as a percentage of premium revenues can result in significant changes in our results of operations, particularly with respect to our products sold through the public exchanges, as we and our competitors have limited experience with pricing such products or the utilization rates for medical or other covered services by members who purchase our products through such exchanges. Further, the public exchange market is currently experiencing significant disruptions, as many insurers have incurred significant losses and announced their withdrawal from public exchange markets in a number of states. For 2016, we experienced losses in our public exchange business as our products were selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these public exchange products. Although we increased our public exchange premiums for 2017, there can be no assurance that these increases in premiums will adequately address the risk that our products continue to be selected by individuals who utilize medical services at a greater rate than anticipated. Health care benefit costs in excess of our cost projections reflected in our public exchange product pricing cannot be recovered in the current premium period through higher premiums. Although federal risk adjustment mechanisms, including risk adjustment payments, could help offset health care benefit costs in excess of our projections if our assumptions regarding cost trends, utilization, enrollment, adverse selection, acuity and other assumptions utilized in setting our premium rates are significantly different than actual results, our income statement and financial position could be adversely affected. If future modifications to Health Care Reform significantly reduce the federal risk adjustment mechanisms, this will impact our assumptions for the next several years.

In addition to the challenge of managing health care costs, we face pressure to contain premium rates. Our customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. For example, the ACA includes an annual rate review requirement to prohibit unreasonable rate increases, and our plans may be excluded from participating in the public exchanges if they are deemed to have a history of "unreasonable" rate increases. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates, including retroactive decreases in Medicaid reimbursement

rates, delays in premium payments or a lack of sufficient increase in reimbursement rates for government-sponsored programs in which we participate. A limitation on our

ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, cash flows, financial condition and results of operations.

The reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in health care costs, expenses, general economic conditions and other factors. To the extent the actual claims experience is unfavorable as compared to our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

Our profitability is dependent in part upon our ability to contract on favorable terms with hospitals, physicians, PBM service providers and other health care providers. Physicians, hospitals and other health care providers may refuse to contract with us, and the failure to secure or maintain cost-effective health care provider contracts on competitive terms may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, consolidation among health care providers, ACO practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, and our business, cash flows, financial condition and results of operations could be adversely affected.

Our inability to contract with providers, or if providers attempt to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, or the inability of providers to provide adequate care, could adversely affect our business. In addition, we do not have contracts with all providers that render services to our members and, as a result, do not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render, which can result in significant litigation or arbitration proceedings, or provider attempts to obtain payment from our members for the difference between the amount we have paid and the amount they have charged.

A significant reduction in the enrollment in our health benefits programs could have an adverse effect on our business and profitability.

A significant reduction in the number of enrollees in our health benefits programs could adversely affect our business, cash flows, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: reductions in workforce by existing customers; general economic downturn that results in business failures and high unemployment rates; employers no longer offering certain health care coverage as an employee benefit or electing to offer coverage on a voluntary, employee-funded basis; participation on public exchanges; federal and state regulatory changes; failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; and failure to attain or maintain nationally recognized accreditations.

There are various risks associated with participating in Medicaid and Medicare programs, including dependence upon government funding and the timing of payments, compliance with government contracts and increased regulatory oversight.

We contract with various federal and state agencies, including CMS, to provide managed health care services, including Medicare Advantage plans, Medicare Supplement plans, Medicare approved prescription drug plans, Medicaid, TANF, SPD, LTSS, CHIP and ACA-related Medicaid expansion programs. We also provide various administrative services for several other entities offering medical and/or prescription drug plans to their Medicare eligible members through our affiliated companies and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We are also participating in Medicare and Medicaid dual eligible programs in several states. These programs in our Government Business segment have been the subject of recent regulatory reform initiatives, including Health Care Reform. It is difficult to predict the future impact of Health Care Reform on our Government Business segment due to Health Care Reform’s complexity and potential for further modifications. Regulatory reform initiatives or additional changes in existing laws or regulations, or their interpretations, could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The base premium rate paid by each state or federal agency differs depending upon a combination of various factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Future Medicare and Medicaid rates may be affected by continued government efforts to contain costs as well as federal and state budgetary constraints. If the federal government or any state in which we operate were to decrease rates paid to us, pay us less than the amount necessary to keep pace with our cost trends or seek an adjustment to previously negotiated rates, it could have a material adverse effect on our business, cash flows, financial condition and results of operations. Further, certain state contracts are subject to cancellation in the event of the unavailability of state funds. In addition, various states' Medicare and Medicaid dual eligible programs are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these new programs. An unexpected reduction, inadequate government funding or significantly delayed payments for these programs may adversely affect our revenues, cash flow and financial results.

A portion of our premium revenue comes from CMS through our Medicare Advantage and Medicare Part D contracts. As a consequence, our Medicare Advantage and Medicare Part D plans are dependent on federal government funding. The premium rates paid to Medicare plans are established based on benchmarks which are now tied to a percentage of Medicare fee for service, although the rates differ depending on a combination of factors, including upper payment limits established by CMS, a member's health profile and status, age, gender, county or region, benefit mix, member eligibility categories and risk scores. In addition, Medicare Advantage and Medicare Part D plans are subject to MLR rules. Continuing government efforts to contain health care related expenditures, including prescription drug cost, and other federal budgetary constraints that result in changes in the Medicare program, including changes with respect to funding, could lead to reductions in the amount of reimbursement, or other changes that could have a material adverse effect on our business, cash flows, financial condition and results of operations. Risks associated with the Medicare Advantage and Medicare Part D plans include increased medical or pharmaceutical costs, overpayments identified as a result of ongoing auditing and monitoring activities, potential uncollectability of receivables resulting from processing and/or verifying enrollment, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members, and limited enrollment periods. While we believe we have adequately reviewed our assumptions and estimates regarding these complex and wide-ranging programs under Medicare Advantage and Medicare Part D, including those related to collectability of receivables and establishment of liabilities, actual results may be materially different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations. There is also the possibility that Medicare Advantage Special Needs plans, which are authorized through December 31, 2018, will not be re-authorized by Congress. If the Special Needs plans are not re-authorized, there could be a loss of revenue and it would become more difficult to coordinate Medicare benefits with other coverage. Finally, there is the possibility that the Medicare Advantage program could be significantly impacted by any future modification, repeal or replacement of Health Care Reform,

Our contracts with CMS and state governmental agencies contain certain provisions regarding data submission, provider network maintenance, quality measures, claims payment, continuity of care, call center performance and other requirements specific to federal and state program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties, liquidated damages and retrospective adjustments in payments made to our health plans, that could impact our profitability. In addition, we could be required to file a corrective plan of action with additional penalties for noncompliance, including a negative impact on future membership enrollment levels. Further, certain of our CMS and state Medicaid contracts are subject to a competitive procurement process. If our existing contracts are not renewed, or if we are not awarded new contracts as a result of the competitive procurement process, it could have a material adverse effect on our business, cash flows, financial condition and results of operations. Further, the Medicare Advantage Star Ratings System utilized by CMS to evaluate Medicare Advantage Plans may have a significant effect on our results of operations, as higher rated plans tend to experience increased enrollment and plans with a star rating of 4.0 or higher are eligible for quality-based bonus payments. Our star ratings may be negatively impacted if we fail to meet the quality, performance and regulatory compliance criteria established by

CMS. If our star ratings decline, fail to meet or exceed our competitors' ratings or fall short of our expectations, or if quality-based bonus payments associated with star ratings are reduced or eliminated, our financial performance may be adversely impacted.

In addition to the contractual requirements affecting our participation in Medicaid and Medicare programs, we are also subject to various federal and state health care laws and regulations, including those directed at preventing fraud and abuse in

government funded programs. Failure to comply with these laws and regulations could result in investigations, litigation, fines, restrictions on, or exclusions from, program participation, the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency that could adversely impact our business, cash flows, financial condition and results of operations.

We are regularly subject to CMS audits of our Medicare Advantage plans to validate the diagnostic data and patient claims, as well as audits of our Medicare Part D plans by the Medicare Part D Recovery Audit Contractor, or RAC. These audits could result in retrospective adjustments in payments made to our health plans. In addition to these federal programs, a number of states have implemented Medicaid RAC programs which were authorized by the ACA. State RAC programs could increase the number of audits and any subsequent recoupment by the federal and state governments, which could adversely affect our financial condition and results of operations. If we fail to report and correct errors discovered through our own auditing procedures or during a CMS or RAC audit, or otherwise fail to comply with 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 these programs, and on our financial condition, cash flows and results of operations.

In addition, there are an increasing number of investigations regarding compliance with various provisions of the ACA. These investigations are being conducted by both CMS and state regulators. As a result, we could be subject to multiple investigations of the same issue. These investigations, and any possible 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 may not complete the acquisition of Cigna within the time frame we anticipate or at all, which could have a negative effect on our business or our results of operations.

On July 23, 2015, we entered into an Agreement and Plan of Merger, or Merger Agreement, under which we will acquire all of the outstanding shares of Cigna. The acquisition is subject to a number of closing conditions, such as antitrust and other regulatory approvals, which may not be received or may take longer than expected. The acquisition is also subject to other risks and uncertainties. If the acquisition is not consummated within the expected time frame, or at all, it could have a negative effect on our ability to execute on our growth strategy or on our financial performance.

Failure to complete the acquisition could negatively impact our share price and future business, as well as our financial results.

If the acquisition is not completed, our ongoing business may be adversely affected and, without realizing any of the benefits of having completed the acquisition, we could be subject to a number of risks, including the following: we may be required to pay Cigna a termination fee of $1.85 billion or an expense fee of up to $600 million if the Merger Agreement is terminated under certain circumstances (as more fully described in the Merger Agreement); and we could be subject to litigation related to any failure to complete the acquisition or related to any enforcement proceeding commenced against us to perform our obligations under the Merger Agreement. If the acquisition is not completed, these risks may materialize and may adversely affect our business, cash flows and financial condition.

Cigna’s pursuit of litigation to terminate the Merger Agreement and seeking damages against us, together with our own litigation against Cigna, could cause us to incur substantial costs, may present material distractions and, if decided adverse to Anthem, could negatively impact our financial position.

As described in Note 3, Business Acquisitions and Divestiture - Pending Acquisition of Cigna Corporation, to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, on February 14, 2017, Cigna commenced litigation for a declaratory judgment that its purported termination of the Merger Agreement was lawful and seeking damages against us. We promptly filed our own litigation against Cigna seeking to compel Cigna’s specific performance of the Merger Agreement and damages against Cigna. These lawsuits could result in substantial costs to us, including litigation costs and potential settlement costs. Further, due to the potential significance of the allegations and damages claimed by Cigna, we expect that our officers will spend substantial time focused on the litigation. Our defense against Cigna’s claims, the pursuit of our claims or the settlement, or failure to reach a settlement, for any claims may result in negative media attention, and may adversely affect our business, reputation, financial condition, results of operations, cash flows and market price.

We may experience difficulties in integrating Cigna's business and realizing the expected benefits of the proposed acquisition.

The success of the Cigna acquisition, if completed, will depend, in part, on our ability to realize the anticipated business opportunities and growth prospects from combining our businesses with those of Cigna. We may never realize these business opportunities and growth prospects. Integrating operations will be complex and will require significant efforts and expenditures on the part of both us and Cigna. Our management might have its attention diverted while trying to integrate operations and corporate and administrative infrastructures. We might experience increased competition that limits our ability to expand our business, and we might fail to capitalize on expected business opportunities, including retaining current customers.

The integration process could result in a disruption of each company's ongoing businesses, tax costs or inefficiencies, or inconsistencies in standards, controls, information technology systems, procedures and policies, any of which could adversely affect our ability to maintain relationships with clients, employees or other third parties or our ability to achieve the anticipated benefits of the Cigna acquisition and could harm our financial performance.

If we are unable to successfully or timely integrate the operations of Cigna's business into our business, we may be unable to realize the revenue growth, synergies and other anticipated benefits resulting from the proposed acquisition and our business and results of operations could be adversely affected. Even if we complete the Cigna acquisition, the acquired business may underperform relative to our expectations.

The health benefits industry is subject to negative publicity, which could adversely affect our business and profitability.

The health benefits industry is subject to negative publicity, which can arise from, among other things, the ongoing debate over Health Care Reform, industry consolidation, increases in premium rates and the decision of many insurers to withdraw from, or significantly curtail their participation in, public exchanges. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by adversely affecting our ability to market our products and services, requiring us to change our products and services, or increasing the regulatory burdens under which we operate.

In addition, as long as we use the Blue Cross and Blue Shield names and marks in marketing our health benefits products and services, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services. Any such negative publicity could adversely affect our business, cash flows, financial condition and results of operations.

We face competition in many of our markets and customers and brokers have flexibility in moving between competitors.

As a health benefits company, we operate in a highly competitive environment and in an industry that is subject to significant changes from legislative reform, business consolidations, new strategic alliances, aggressive marketing practices by other health benefits organizations and market pressures brought about by an informed and organized customer base, particularly among large employers. For example, we began to compete for sales on public exchanges in 2014, which has required, and will continue to require, us to develop or acquire the tools, including social media tools, necessary to interact with the exchanges and with consumers using the exchanges, increase our focus on individual customers and improve our consumer-focused sales and marketing, customer interfaces and product offerings. These factors have produced and will likely continue to produce significant pressures on our profitability.

We also will have to respond to pricing and other actions taken by existing competitors and potentially disruptive new entrants. Due to the price transparency provided by public exchanges, we face competitive pressures from new and existing competitors in the market for individual health insurance. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of private insurance exchanges or encourage their employees to purchase health insurance on the public exchanges. We can provide no assurance that we will be able to compete successfully on these public exchanges or that we will be able to benefit from any opportunities presented by such exchanges. If we are not competitive on these public exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely impacted.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our health care products, particularly with respect to individuals, seniors and small employer group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address Health Care Reform legislation, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

We face intense competition to attract and retain employees. Further, managing key executive succession and retention is critical to our success.

Our success depends on our ability to attract and retain qualified employees to meet current and future needs, integrating and engaging employees who have joined us through acquisitions and achieving productivity gains from our investment in technology. 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. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We would be adversely affected if we fail to adequately plan for succession of our Chairman, President and Chief Executive Officer and other senior management and retention of key executives. While we have succession plans in place for members of our senior management, and continue to review and update those plans, and we have employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract and retain suitable successors.

A change in our health care product mix may impact our profitability.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services products and those health care products where the employer groups assume the underwriting risks. 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. In addition, our products sold on the public exchanges have been less profitable than our other insurance products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our financial condition and results of operations.

If we fail to adequately adapt to changes in our industry and develop and implement strategic growth opportunities, our ability to grow may be adversely affected.

As a result of significant changes to traditional health insurance in recent years brought about by Health Care Reform and other factors, the health insurance industry has experienced a significant shift in membership to insurance products with lower margins. Moreover, the significant modification, repeal or replacement of Health Care Reform could have far-reaching consequences for our business. In order to profitably grow our business in the future, we need to not only grow our profitable medical membership, but also continue to diversify our sources of revenue and earnings, including through the increased sale of our specialty products, such as dental, vision and other supplemental products, expansion of our non-insurance assets and establishment of new cost of care solutions, including innovations in PBM services. If we are unable to acquire or develop and successfully manage new opportunities that further our strategic objectives and differentiate our products from our competitors, our ability to profitably grow our business could be adversely affected.

As a holding company, we are dependent on dividends from our subsidiaries. These dividends are necessary to pay our outstanding indebtedness. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends, maintenance of minimum levels of capital and restrictions on investment portfolios.

We are a holding company whose assets include the outstanding shares of common stock (or other ownership interest) of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. Our subsidiaries are separate legal entities. As a holding company, we depend on dividends from our subsidiaries. Furthermore,

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our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. In some states, we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards, imposed by their states of domicile. These laws are based on the RBC Model Act adopted by the NAIC and require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. As discussed in more detail below, we are a party to license agreements with the BCBSA which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of their investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on our investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future in connection with the Cigna acquisition or otherwise. Such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate in permitting us to meet scheduled debt service obligations.

If the Cigna acquisition is consummated, we expect to have incurred acquisition-related indebtedness of approximately $26.5 billion and to have assumed approximately $5.1 billion of Cigna's outstanding debt. Our substantially increased indebtedness and debt-to-equity ratio on a recent historical basis will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and may increase our borrowing costs. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources may be greater than the percentages of cash flows required to service our indebtedness or the indebtedness of Cigna individually prior to the acquisition. The increased levels of indebtedness could also reduce funds available for our investments in product development as well as capital expenditures, share repurchases, shareholder dividends, other desirable business opportunities and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

In addition to the expected acquisition-related debt financing described above, we may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit agreement or other indebtedness. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement or our other indebtedness is accelerated, we may be unable to repay or finance the amounts due.

A downgrade in our credit ratings could have an adverse effect on our business, financial condition and results of operations.

Claims-paying ability and financial strength ratings by nationally recognized statistical rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. We believe our strong credit ratings are an important factor in marketing our products to customers, since credit ratings information is broadly disseminated and generally used throughout the industry. In addition, if our credit ratings are downgraded or placed under review, our business, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs. Our ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders and creditors, and are not evaluations directed toward the protection of investors in our common stock. 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. Following the announcement of the Cigna acquisition, 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 a possible downgrade.

We face risks related to litigation.

We are, or may in the future, be a party to a variety of legal actions that may affect any business, such as employment and employment discrimination-related suits and administrative charges before government agencies, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, administration and offering of our products and services. These could include claims relating to the denial of health care benefits; the rescission of health insurance policies; development or application of medical policy; medical malpractice actions; product liability claims; allegations of anti-competitive and unfair business activities; provider disputes over compensation; provider tiering programs; narrow networks; termination of provider contracts; the recovery of overpayments from providers; self-funded business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business or corporate governance practices; the failure to comply with various state or federal laws, including but not limited to, ERISA and the Mental Health Parity Act; and customer audits and contract performance, including government contracts. These actions or proceedings could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition, we are also involved in, or may in the future be party to, pending or threatened litigation of the character incidental to the business transacted or arising out of our operations or our 2001 demutualization, including, but not limited to, breaches of security and violations of privacy requirements (including as a result of the cyber attack reported by us in February 2015, as more fully described under Note 13, "Commitments and Contingencies - Cyber Attack Incident," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K), shareholder actions, compliance with federal and state laws and regulations (including qui tam or "whistleblower" actions), or sales and acquisitions of businesses or assets. From time to time, we are involved as a party in various governmental investigations, audits, reviews and administrative proceedings, including challenges to the award of government contracts by disappointed bidders. These investigations, audits and reviews include routine and special investigations by various state insurance departments, state attorneys general and the U.S. Attorney General. Following an investigation, we may be subject to civil or criminal fines, penalties and other sanctions if we are determined to be in violation of applicable laws or regulations. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations or financial position.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), treble or punitive damages may be sought. Although we maintain insurance coverage for some of these potential liabilities, some liabilities and damages may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could have an adverse effect on our cash flows, results of operations and financial condition.

Further, litigation brought against the federal and some state governments over Health Care Reform could have a material adverse effect on our business, cash flows, financial condition and results of operations as changes to Health Care Reform resulting from this litigation create uncertainty over the applicability and enforceability of portions of the law and the various regulations, which impacts our strategy and could negatively impact our future growth opportunities.

Our future obligations for state guaranty association assessments could increase in the event of increased insolvencies of health insurance plans.

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when a health insurance plan becomes insolvent. Most state insolvency or guaranty association laws provide for assessments based upon the amount of premiums received on insurance underwritten within such state. Although health insurance company insolvencies have been infrequent, we have experienced increased assessments in recent years after a number of smaller health insurance companies and Consumer Operated and Oriented Plans failed to establish premiums that were sufficient to cover the cost of care for their members. We may continue to experience increased assessments in the future if premiums established by other companies for their health insurance products, including certain long-term care products, are inadequate to cover the cost of care. We are not currently able to estimate our potential financial obligations, losses, or the availability of potential offsets associated with potential increases in guaranty association assessments; however, any significant increase in guaranty association assessments could have a material adverse effect on our business, cash flows, financial condition and results of operations.

There are various risks associated with providing health care services.

The direct provision of health care services by our CareMore subsidiary involves risks of additional litigation arising from medical malpractice actions based on our treatment decisions or brought against us or our physician associates for alleged malpractice or professional liability claims arising out of the delivery of health care and related services. In addition, liability may arise from maintaining health care premises that serve the public. If we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our cash flows, financial condition and results of operations.

Additionally, many states in which our CareMore subsidiary operates limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians (“corporate practice of medicine”) and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state. Further, certain federal and state laws, including those covering our Medicare and Medicaid plans, prohibit the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of patient care opportunities, including, but not limited to, Medicare patients, and also generally prohibit physicians from making referrals to any entity providing certain designated health services if the referring physician or related person has an ownership or financial interest in the entity. Any enforcement actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition and results of operations.

We are a party to license agreements with the BCBSA that entitle us to the exclusive and in certain areas non-exclusive use of the Blue Cross and Blue Shield names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, financial condition and results of operations. Upon completion of the Cigna acquisition, we may not initially be in compliance with the BCBSA’s national “best efforts” requirement.

We use the Blue Cross and Blue Shield names and marks as identifiers for our products and services under licenses from the BCBSA. Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the Blue Cross and Blue Shield names and marks, including: minimum capital and liquidity requirements imposed by the BCBSA; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the Blue Cross and Blue Shield system in contracts with third parties and in public statements; plan governance requirements; cyber security requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee’s annual

combined local net revenue, as defined by the BCBSA,

attributable to health care plans and related services within its service areas must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. Failure to comply with the foregoing requirements could result in a termination of the license agreements.

In addition, our license agreements with the BCBSA include a requirement that at least 66 2/3% of our annual combined national net revenue, as defined by the BCBSA, attributable to health care plans and related services must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks, referred to as the "National Best Efforts Requirement." Due to the size of Cigna's business, we may not be in compliance with the National Best Efforts Requirement immediately after completion of the acquisition.

We will be required to submit an action plan for coming into compliance with the National Best Efforts Requirement within 120 days of the completion of the Cigna acquisition if we are out of compliance following closing of the acquisition. Under current BCBSA standards, we would be required to cure any non-compliance with the National Best Efforts Requirement within 24 months from the date when the relevant BCBSA committee makes a determination on our action plan. We believe there are multiple options at our disposal to regain compliance within the allotted timeframe, if necessary. Although we strongly believe there would be numerous ways in which we could re-establish compliance with the National Best Efforts Requirement within the required 24 month period, there can be no guarantee such efforts will be successful, and failure to comply with the requirement could ultimately result in a termination of our license agreements under certain circumstances.

The standards under the license agreements may be modified in certain instances by the BCBSA. For example, from time to time there have been proposals considered by the BCBSA to modify the terms of the license agreements to restrict various potential business activities of licensees. These proposals have included, among other things, a limitation on the ability of a licensee to make its provider networks available to insurance carriers or other entities not holding a Blue Cross or Blue Shield license. To the extent that such amendments to the license agreements are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations, or our ability to come back into compliance with the National Best Efforts Requirement if the Cigna acquisition is consummated. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. If we or another BCBS licensee is not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the Blue Cross and Blue Shield names and marks or to sell Blue Cross and Blue Shield health insurance products and services in one or more of our service areas. Furthermore, the BCBSA would be free to issue a license to use the Blue Cross and Blue Shield names and marks in these service areas to another entity. Our existing Blue Cross and Blue Shield members would be provided with instructions for obtaining alternative products and services licensed by the BCBSA. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, failure to comply with governance requirements such as maintaining a classified board structure, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. We believe that the Blue Cross and Blue Shield names and marks are valuable identifiers of our products and services in the marketplace.

Upon termination of a license agreement, the BCBSA would have the right to impose a "Re-establishment Fee" upon us, which would be used in part to fund the establishment of a replacement Blue Cross and/or Blue Shield licensee in the vacated service area. The fee is set at $98.33 per licensed enrollee. As of December 31, 2016, we reported 30.0 million Blue Cross and/or Blue Shield enrollees. If the Re-establishment Fee was applied to our total Blue Cross and/or Blue

Shield enrollees,

we would be assessed approximately $2.9 billion by the BCBSA. As a result, termination of the license agreements would have a material adverse effect on our business, financial condition and results of operations.

Regional concentrations of our business may subject us to economic downturns in those regions.

The states in which we operate that have the largest concentrations of revenues include California, Georgia, Indiana, New York, Ohio, Texas and Virginia. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state specific or regional economic downturns impacting these states. If such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies may have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. For example, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological and other weapons. In addition, natural disasters such as hurricanes and the potential for a widespread pandemic of influenza coupled with the lack of availability of appropriate preventative medicines can have a significant impact on the health of the population of widespread areas. If the United States were to experience widespread bioterrorism or other attacks, large-scale natural disasters in our concentrated coverage areas or a large-scale pandemic or epidemic, our covered medical expenses could rise and we could experience a material adverse effect on our business, cash flows, financial condition and results of operations or, in the event of extreme circumstances, our viability could be threatened.

We have built a significant portion of our current business through mergers and acquisitions, joint ventures and strategic alliances and we expect to pursue such opportunities in the future.

The following are some of the risks associated with mergers, acquisitions, joint ventures and strategic alliances, referred to collectively as business combinations, that could have a material adverse effect on our business, cash flows, financial condition and results of operations:

- some of the acquired businesses may not achieve anticipated revenues, earnings or cash flow, business opportunities, synergies, growth prospects and other anticipated benefits;
- the goodwill or other intangible assets established as a result of our business combinations may be incorrectly valued or become non-recoverable;
- we may assume liabilities that were not disclosed to us or which were under-estimated;
- we may experience difficulties in integrating acquired businesses, be unable to integrate acquired businesses successfully or as quickly as expected, and be unable to realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems;
- business combinations, and proposed business combinations that are not completed, could disrupt our ongoing business, lead to the incurrence of significant fees, 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 and procedures;
- we may finance future business combinations by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may also incur additional debt related to future business combinations;
- we would be competing with other firms, some of which may have greater financial and other resources, to acquire attractive companies; and
- future business combinations may make it difficult to comply with the requirements of the BCBSA and lead to an increased risk that our BCBSA license agreements may be terminated.

The value of our intangible assets may become impaired.

Due largely to our past mergers, acquisitions and divestitures, goodwill and other intangible assets represent a substantial portion of our assets. If we make additional acquisitions, it is likely that we will record additional intangible assets on our consolidated balance sheets. The value we place on intangible assets may be adversely impacted if acquired businesses fail to perform in a manner consistent with our assumptions.

In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to income may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

In addition, the estimated value of our reporting units may be impacted as a result of business decisions we make associated with the implementation of the various Health Care Reform regulations. Such decisions, which could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets, could result in impairment charges in future periods.

Adverse securities and credit market conditions may significantly affect our ability to meet liquidity needs.

During periods of increased volatility, adverse securities and credit markets may exert downward pressure on the availability of liquidity and credit capacity for certain issuers. We need liquidity to pay our operating expenses, make payments on our indebtedness and pay capital expenditures. The principal sources of our cash receipts are premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings and proceeds from the issuance of common stock under our employee stock plans.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the volume of trading activities, the availability of credit to our industry, our credit ratings and credit 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 may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

The market values of our investments vary from time to time depending on economic and market conditions. For various reasons, we may sell certain of our investments at prices that are less than the carrying value of the investments. During periods in which interest rates are relatively low, as in recent years, our investment income could be adversely impacted. In addition, in periods of declining interest rates, bond calls and mortgage loan prepayments generally increase, resulting in the reinvestment of these funds at the then lower market rates. In periods of rising interest rates, the market values of our fixed maturity securities will generally decrease, which could result in material unrealized or realized losses on investments in future periods. In addition, defaults by issuers, primarily from investments in corporate and municipal bonds, who fail to pay or perform their obligations, could reduce net investment income, which would adversely affect our profitability. We cannot assure you that our investment portfolios will produce positive returns.

In accordance with FASB guidance for debt and equity investments, we classify fixed maturity and equity securities in our investment portfolio as “available-for-sale” or “trading” and report those securities at fair value. Current and long-term available-for-sale investment securities represented a significant percentage of our total consolidated assets at December 31, 2016.

Changes in the economic environment, including periods of increased volatility of the securities markets, can increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. We believe we have adequately reviewed our investment securities for impairment and we believe that we have appropriately estimated the fair values of our investment securities. However, over time, the economic and market environment may provide additional insight, which could change our judgment regarding the fair value of certain securities and/or impairment. Given the sometimes rapidly changing market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments may be charged to income in future periods, resulting in realized losses.

We may not be able to realize the value of our deferred tax assets.

In accordance with applicable accounting standards, we separately recognize deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded.

At each financial reporting date, we evaluate our deferred tax assets to determine the likely realization of the benefit of the temporary differences. Our evaluation includes a review of the types of temporary differences that created the deferred tax asset; the amount of taxes paid on both capital gains and ordinary income in prior periods and available for a carry-back claim; the forecasted future taxable income, and therefore, the likely future deduction of the deferred tax item; and any other significant issues that might impact the realization of the deferred tax asset. If it is more likely than not that all or a portion of the deferred tax asset may not be realized, we establish a valuation allowance. Significant judgment is required in determining an appropriate valuation allowance.

Any future increase in the valuation allowance would result in additional income tax expense and a decrease in shareholders’ equity, which could materially affect our financial position and results of operations in the period in which the increase occurs. A material decrease in shareholders’ equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

An unauthorized disclosure of sensitive or confidential member or employee information, including by cyber attack or other security breach, could cause a loss of data, give rise to remediation or other expenses, expose us to liability under federal and state laws, and subject us to litigation and investigations, which could have an adverse effect on our business, cash flows, financial condition and results of operations.

As part of our normal operations, we collect, process and retain certain sensitive and confidential information. We are subject to various federal, state and international laws and rules regarding the use and disclosure of certain sensitive or confidential information, including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act, and numerous state laws governing personal information. Despite the security measures we have in place to help ensure data security and compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to cyber attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events.

In February 2015, we reported the discovery that certain of our information technology systems had been the target of an external cyber attack, as more fully described under Note 13, “Commitments and Contingencies - Cyber Attack Incident,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. We have incurred expenses to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Actions have been filed in various federal and state courts and other claims have been or may be asserted against us, allegedly arising out of the cyber attack. Further, we may be subject to additional litigation and governmental investigations which could divert the attention of management from the operation of our business, result in reputational damage and have a material adverse impact on our business, cash flows, financial

condition and results of operations. While we have contingency plans and insurance coverage for potential liabilities of this nature, these may not be sufficient to cover all claims and liabilities.

In addition, we cannot ensure that we will be able to identify, prevent or contain the effects of additional cyber attacks or other cybersecurity risks in the future that bypass our security measures or disrupt our information technology systems or business. As a result, cybersecurity and the continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage and unauthorized access, remain a priority for us. Noncompliance with any privacy or security laws and regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the misappropriation, loss or other unauthorized disclosure or use of, or access to, sensitive or confidential member information, whether by us or by one of our vendors, could require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could result in interruptions to our operations and damage our reputation, and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

The failure to effectively maintain and upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses. As a result of our merger and acquisition activities, we have acquired additional systems. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, emerging cybersecurity risks and threats, evolving industry and regulatory standards including public exchanges and other aspects of Health Care Reform, compliance with legal requirements, private insurance exchanges and changing customer preferences. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties fail to perform adequately.

Failure to adequately implement and maintain effective and efficient information systems with sufficiently advanced technological capabilities, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could result in competitive and cost disadvantages to us compared to our competitors, a diversion of management’s time and could have a material adverse effect on our business, financial condition and results of operations. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to adequately maintain our information systems and data integrity effectively, we could experience problems in determining medical cost estimates and establishing appropriate pricing and reserves, incur disputes with customers and providers, incur regulatory problems, including sanctions and penalties, incur increases in operating expenses or suffer other adverse consequences, including a decrease in membership.

We are dependent on the success of our relationships with third parties for various services and functions, including PBM services.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our business infrastructure and operating requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions 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 could adversely affect our business, reputation, cash flows, financial condition and operating results.

In particular, we are a party to an agreement with Express Scripts whereby Express Scripts is the exclusive provider of certain PBM services to our plans, excluding our CareMore subsidiary and certain self-insured members, who have exclusive agreements with different PBM service providers. The Express Scripts PBM services include, but are not limited to, pharmacy network management, mail order and specialty drug fulfillment, claims processing, rebate management and specialty pharmaceutical management services. Accordingly, the agreement contains certain financial and operational requirements obligating both Express Scripts and us. The failure of either party to meet the respective requirements could potentially serve as a basis for early termination of the contract. As more fully

described under Note 13, “Commitments and

Contingencies - Litigation," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, we filed suit against Express Scripts in March 2016 alleging breaches of the agreement, and Express Scripts filed a countersuit. If this relationship was terminated, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations, particularly if Express Scripts failed to provide post-termination services. In addition, our failure to meet certain minimum script volume requirements results in financial penalties that could have a material adverse effect on our results of operations.

Indiana law, other applicable laws, our articles of incorporation and bylaws, and provisions of our BCBSA license agreements may prevent or discourage takeovers and business combinations that our shareholders might consider in their best interest.

Indiana law and our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

We are regulated as an insurance holding company and subject to the insurance holding company acts of the states in which our insurance company subsidiaries are domiciled, as well as similar provisions included in the health statutes and regulations of certain states where these subsidiaries are regulated as managed care companies or HMOs. The insurance holding company acts and regulations and these similar health provisions restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes and regulations, without such approval or an exemption, no person may acquire any voting security of a domestic insurance company or HMO, or an insurance holding company which 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, insurance company or HMO. "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. Further, the Indiana business corporation law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder's acquisition of the stock was approved in advance by our Board of Directors.

Our articles of incorporation restrict the beneficial ownership of our capital stock in excess of specific ownership limits. The ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors, both as defined in our articles of incorporation. Additionally, no person may beneficially own shares of our common stock representing a 20% or more ownership interest in us. These restrictions are intended to ensure our compliance with the terms of our licenses with the BCBSA. Our articles of incorporation prohibit ownership of our capital stock beyond these ownership limits without prior approval of a majority of our continuing directors (as defined in our articles of incorporation). In addition, as discussed above in the risk factor describing our license agreements with the BCBSA, such license agreements are subject to termination upon a change of control and re-establishment fees would be imposed upon termination of the license agreements.

Certain other provisions included in our articles of incorporation and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider in their best interests. In particular, our articles of incorporation and bylaws: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreement with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; restrict the maximum number of directors; limit the ability of shareholders to remove directors; impose restrictions on shareholders' ability to fill vacancies on our Board of Directors; prohibit shareholders from calling special meetings of shareholders; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and prohibit shareholders from amending our bylaws.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- any requirement to restate financial results in the event of inappropriate application of accounting principles;

- a significant failure of our internal control over financial reporting;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

Our principal executive offices are located at 120 Monument Circle, Indianapolis, Indiana. In addition to this location, we have significant operating facilities located in each of the fourteen states where we operate as licensees of the BCBSA, in each of the additional ten states where Amerigroup conducts business and in the additional state of Arizona where CareMore conducts business. A majority of these locations are leased properties. Our facilities support our various business segments. We believe that our properties are adequate and suitable for our business as presently conducted as well as for the foreseeable future.

ITEM 3. LEGAL PROCEEDINGS.

For information regarding our legal proceedings, see the “Litigation,” “Cyber Attack Incident” and “Other Contingencies” sections of Note 13, “Commitments and Contingencies” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

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 Prices

Our common stock, par value $0.01 per share, is listed on the NYSE under the symbol "ANTM." On February 10, 2017, the closing price on the NYSE was $162.32. As of February 10, 2017, there were 67,279 shareholders of record of our common stock. The following table presents high and low sales prices for our common stock on the NYSE for the periods indicated.

	High	Low
2016		
First Quarter	$144.69	$115.63
Second Quarter	148.00	122.91
Third Quarter	143.18	122.52
Fourth Quarter	148.26	114.85
2015		
First Quarter	$160.64	$122.86
Second Quarter	173.59	148.29
Third Quarter	165.93	134.62
Fourth Quarter	149.87	126.25

Dividends

The quarterly cash dividend declared by our Board of Directors was $0.6500, $0.6250, and $0.4375, per share in 2016, 2015 and 2014, respectively. On February 22, 2017, our Board of Directors declared a quarterly cash dividend to shareholders of $0.6500 per share.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors. Further, our ability to pay dividends to our shareholders, if authorized by our Board of Directors, is significantly dependent upon the receipt of dividends from our subsidiaries, including Anthem Insurance Companies, Inc., Anthem Southeast, Inc., Anthem Holding Corp., WellPoint Holding Corp., WellPoint Acquisition, LLC, WellPoint Insurance Services, Inc., ATH Holding Company, LLC, Anthem Partnership Holding Company, LLC and SellCore, Inc. The payment of dividends by our insurance subsidiaries without prior approval of the insurance department of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective insurance departments.

Under the terms of the Merger Agreement with Cigna, during the period before completion of the merger, we will not declare, set aside, make or pay any dividend with respect to our capital stock, other than (1) regular quarterly cash dividends with declaration, record and payment dates consistent with past practice and in accordance with our dividend policy as of the date of the Merger Agreement and (2) dividends payable by a directly or indirectly wholly owned subsidiary to Anthem or to another directly or indirectly wholly owned subsidiary of Anthem. The cash dividend declared by our Board of Directors on February 22, 2017 was in accordance with the terms of the Merger Agreement.

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 set forth in or incorporated by reference into Part III, Item 12 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K.

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated:

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs[2]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
(In millions, except share and per share data)				
October 1, 2016 to October 31, 2016	7,712	$ 123.03	—	$ 4,175.9
November 1, 2016 to November 30, 2016	963	121.52	—	4,175.9
December 1, 2016 to December 31, 2016	7,765	144.80	—	4,175.9
	16,440		—	

1 Total number of shares purchased represents shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.

2 Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. There were no share repurchases under the common stock repurchase program during the year ended December 31, 2016. The Board of Directors has authorized our common stock repurchase program since 2003. The Board's most recent authorized increase to the program was $5,000.0 on October 2, 2014. No duration has been placed on our common stock repurchase program and we reserve the right to discontinue the program at any time.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2011 through December 31, 2016, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's Managed Health Care Index (the "S&P Managed Health Care Index"). The graph assumes an investment of $100 on December 31, 2011 in each of our common stock, the S&P 500 Index and the S&P Managed Health Care Index (and the reinvestment of all dividends).

The comparisons shown in the graph below are based on historical data and we caution that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from S&P Capital IQ, a source believed to be reliable, but we are not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed "soliciting materials" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.

	December 31,					
	2011	2012	2013	2014	2015	2016
Anthem, Inc.	$100	$ 94	$145	$200	$226	$237
S&P 500 Index	100	116	154	175	177	198
S&P Managed Health Care Index	100	106	157	209	255	305

Based upon an initial investment of $100 on December 31, 2011 with dividends reinvested.

ITEM 6. SELECTED FINANCIAL DATA.

The table below provides selected consolidated financial data of Anthem. 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 the audited consolidated financial statements and notes as of and for the year ended December 31, 2016 included in Part II, Item 8 “Financial Statements and Supplementary Data,” and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in this Annual Report on Form 10-K.

	As of and for the Years Ended December 31				
	2016	2015 [1]	2014 [2]	2013 [2]	2012 [1, 2]
(in millions, except where indicated and except per share data)					
Income Statement Data					
Total operating revenue [3]	$84,104.0	$78,404.8	$73,021.7	$70,191.4	$60,514.0
Total revenues	84,863.0	79,156.5	73,874.1	71,023.5	61,497.2
Income from continuing operations	2,469.8	2,560.0	2,560.1	2,634.3	2,651.0
Net income	2,469.8	2,560.0	2,569.7	2,489.7	2,655.5
Per Share Data					
Basic net income per share - continuing operations	$9.39	$9.73	$9.28	$8.83	$8.25
Diluted net income per share -	9.21	9.38	8.96	8.67	8.17

continuing operations					
Dividends per share	2.60	2.50	1.75	1.50	1.15
Other Data (unaudited)					
Benefit expense ratio[4]	84.8 %	83.3 %	83.1 %	85.1 %	85.3 %
Selling, general and administrative expense ratio[5]	14.9 %	16.0 %	16.1 %	14.2 %	14.3 %
Income from continuing operations before income taxes as a percentage of total revenues	5.4 %	5.9 %	5.9 %	5.4 %	6.3 %
Net income as a percentage of total revenues	2.9 %	3.2 %	3.5 %	3.5 %	4.3 %
Medical membership (in thousands)	39,919	38,599	37,499	35,653	36,130
Balance Sheet Data					
Cash and investments	$25,519.0	$23,124.7	$23,777.7	$22,395.9	$22,464.6
Total assets	65,083.1	61,717.8	61,676.3	59,095.3	58,610.7
	14,358.5	15,324.5	14,019.6	13,477.4	14,069.3

Long-term debt, less current portion	25,100.4	23,044.1	24,251.3	24,765.2	23,802.7
Total liabilities	39,982.7	38,673.7	37,425.0	34,330.1	34,808.0
Total shareholders' equity	25,100.4	23,044.1	24,251.3	24,765.2	23,802.7

1 The net assets of and results of operations for Simply Healthcare Holdings, Inc. and AMERIGROUP Corporation are included from their respective acquisition dates of February 17, 2015 and December 24, 2012.

2 The operating results of 1-800 CONTACTS, Inc. are reported as discontinued operations at December 31, 2014, 2013 and 2012 as a result of the divestiture completed on January 31, 2014. Included in net income for the year ended December 31, 2014 is income from discontinued operations, net of tax, of $9.6. Included in net income for the year ended December 31, 2013 is a loss from discontinued operations, net of tax, of $144.6. Included in net income for the year ended December 31, 2012 is income from discontinued operations, net of tax, of $4.5.

3 Operating revenue is obtained by adding premiums, administrative fees and other revenue.

4 The benefit expense ratio represents benefit expenses as a percentage of premium revenue.

5 The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total operating revenue.

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

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

This Management's Discussion and Analysis, or MD&A, should be read in conjunction with our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Overview

We manage our operations through three reportable segments: Commercial and Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. As a result, these reportable segments may change in the future.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with the Federal Employee Program, or FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid; Temporary Assistance for Needy Family, or TANF, programs; programs for seniors and people with disabilities, or SPD; programs for long-term services and support, or LTSS; Children's Health Insurance Programs, or CHIP, and Medicaid expansion programs. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes other businesses that do not individually meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Our operating revenue consists of premiums, administrative fees and other revenue. Premium revenue comes from fully-insured contracts where we indemnify our policyholders against costs for covered health and life benefits. Administrative fees come from contracts where our customers are self-insured, or where the fee is based on either processing of transactions or a percent of network discount savings realized. Additionally, we earn administrative fee revenues from our Medicare processing business and from other health-related businesses including disease management programs. Other revenue includes miscellaneous income other than premium revenue and administrative fees.

Our benefit expense primarily includes costs of care for health services consumed by our fully-insured members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service plans, or POS plans;

traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products.

We classify certain claims-related costs as benefit expense to reflect costs incurred for our members' traditional medical care, as well as those expenses which improve our members' health and medical outcomes. These claims-related costs may be comprised of expenses incurred for: (i) medical management, including case and utilization management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy. These types of claims-related costs are designed to ultimately lower our members' cost of care.

Our selling expense consists of external broker commission expenses, and generally varies with premium or membership volume. Our general and administrative expense consists of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Certain variable costs, such as premium taxes, vary directly with premium volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium but are more aligned with changes in membership. The acquisition or loss of a significant block of business would likely impact staffing levels and thus, associated compensation expense. Other variable costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our results of operations depend in large part on our ability to accurately predict and effectively manage health care costs through effective contracting with providers of care to our members and our medical management and health and wellness programs. Several economic factors related to health care costs, such as regulatory mandates of coverage as well as direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating health care costs, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in health care costs, including increases in unit costs and utilization resulting from the aging of the population and other demographics, as well as advances in medical technology, may impose further risks to our ability to profitably underwrite our business, and may have a material impact on our results of operations.

In March 2016, we filed a lawsuit against our vendor for pharmacy benefit management services, Express Scripts, Inc., or Express Scripts, seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches, and seeking various declarations under the agreement between the parties. In April 2016, Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, "Commitments and Contingencies - Litigation," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Merger Agreement, dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and our direct wholly-owned subsidiary, pursuant to which we will acquire all outstanding shares of Cigna, or the Acquisition. This Acquisition will further our goal of creating a premier health benefits company with critical diversification and scale to lead the transformation of health care delivery for consumers. Cigna is a global health services organization that delivers affordable and personalized products and services to customers through employer-based, government-sponsored and individual coverage arrangements. All of Cigna's products and services are provided exclusively by or through its operating subsidiaries, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products including group life, accident and disability insurance. Cigna maintains sales capability in 30 countries and jurisdictions.

Under the terms of the Merger Agreement, Cigna's shareholders will receive $103.40 in cash and 0.5152 shares of our common stock for each Cigna common share outstanding. The value of the transaction is estimated to be approximately $53,000.0 based on the closing price of our common stock on the New York Stock Exchange on July

23, 2015. The final purchase price will be determined based on our closing stock price on the date of closing of the Acquisition. The combined company will reflect a pro forma equity ownership comprised of approximately 67% Anthem shareholders and approximately 33% Cigna shareholders. We expect to finance the cash portion of the Acquisition through available cash on

hand and the issuance of new debt. We are party to a bridge facility commitment letter and a joinder agreement with a group of lenders which provides up to $19,500.0 under a 364-day senior unsecured bridge term loan credit facility to finance the Acquisition in the event that we have not received proceeds from any combination of (i) senior unsecured term loans, (ii) common or preferred equity or equity-linked securities and/or (iii) senior unsecured notes in a public offering or private placement in an aggregate principal amount of at least $19,500.0 prior to the consummation of the Acquisition. In addition, in August 2015, we entered into a term loan facility which will provide up to $4,000.0 to finance a portion of the Acquisition. The commitment of the lenders to provide the bridge facility and the term loan facility is subject to several conditions, including the completion of the Acquisition. We expect that our pro forma debt-to-capital ratio will approximate 49% following the closing of the Acquisition and we are committed to deleveraging to the low 40% range approximately twenty-four months following the closing. We also expect to maintain our common stock dividend and we will maintain flexibility with our share repurchase program. The Acquisition is subject to certain state regulatory approvals, other standard closing conditions and customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act. For additional information, see "Risk Factors" included in Part I, Item 1A; and Note 3, “Business Acquisitions and Divestiture - Pending Acquisition of Cigna Corporation" included in Part II, Item 8 of this Annual Report on Form 10-K.

In July 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia, or District Court, seeking to block the Acquisition. Trial commenced in November 2016 and concluded in January 2017. On January 18, 2017, we provided notice to Cigna that we had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On February 8, 2017, the District Court ruled in favor of the DOJ, and following our motion to expedite the appeal, which was granted on February 17, 2017, we promptly appealed the District Court's ruling to the U.S. Circuit Court of Appeals for the District of Columbia Circuit, or the Appellate Court. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against us in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. We believe Cigna’s allegations are without merit. Also on February 14, 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted our motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. A hearing will be scheduled the week of April 10, 2017. We intend to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remain committed to completing the Acquisition as soon as practicable. If the Merger Agreement is terminated because the required regulatory approvals cannot be obtained, under certain conditions, we could be obligated to pay a $1,850.0 termination fee to Cigna.

On February 17, 2015, we completed our acquisition of Simply Healthcare Holdings, Inc., or Simply Healthcare, a leading managed care company for people enrolled in Medicaid and Medicare programs in the state of Florida. This acquisition aligns with our strategy for continued growth in our Government Business segment. For additional information about this acquisition, see Note 3, “Business Acquisitions and Divestiture - Acquisition of Simply Healthcare" included in Part II, Item 8 of this Annual Report on Form 10-K.

The future results of our operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, became law, causing significant changes to the U.S. health care system. Since then, significant regulations have been enacted by the U.S. Department of Health and Human Services, or HHS, the Department of Labor and the Department of the Treasury. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States, the continuing modification and interpretation of Health Care Reform rules and the potential for significant future changes to the law, we continue to analyze and refine our estimates of the ultimate impact of Health Care

Reform on our business, cash flows, financial condition and results of operations. Health Care Reform presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business are likely to continue for the next several years as elected officials at the national and state level have proposed significant modification to existing laws and regulations, including the potential repeal or

replacement of Health Care Reform. For additional discussion, see Part I, Item 1 “Business - Regulation,” and Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

Pricing in our Commercial and Specialty Business segment, including our Individual and Small Group lines of business, remains competitive and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform and any subsequent changes to the current regulatory scheme.

In the Individual and Small Group markets, we offer on-exchange products through state or federally facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal premium subsidies are available for certain members, subject to income and family size, who purchase public exchange products. We believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

In our Individual markets we offer bronze, silver and gold products, both on and off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the public exchanges, in California and New York.

In our Small Group markets, we offer bronze, silver and gold products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. We offer platinum products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, New York, Virginia and Wisconsin. We offer bronze, silver and gold products, on the public exchanges, in Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio and Virginia. Additionally, we offer platinum products on the public exchange in Connecticut.

Private exchanges have gained visibility in the marketplace based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, in more recent years the Commercial market has received an increased level of attention from the consulting and broker communities as well as health insurance carriers. In response, we have continued our broad-based strategy of offering Anthem Health Marketplace's consumer experience platform to groups, while also participating in four large national consultant-led exchanges, several regional broker-led exchanges and various Individual, Commercial and Medicare exchanges. To date, adoption levels in the Commercial market overall have been lower than analyst predictions. While the ultimate volume, pace of growth and winning business models remain highly uncertain in this space, we continue to believe we are well positioned to adapt with the market as it evolves.

Health Care Reform imposes regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum medical loss ratio, or MLR, and customer rebate requirements; establishment of a mandatory annual Health Insurance Provider Fee, or HIP Fee; creation of a federal rate review process; a requirement to cover preventive services on a first dollar basis; the establishment of public exchanges and essential benefit packages and greater limitations on how we price certain of our products. In addition, the legislation reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time and limits the amount of executive compensation that is deductible for income tax purposes.

As a result of Health Care Reform, HHS issued MLR regulations that require us to meet minimum MLR thresholds for Large Group, Small Group and Individual lines of business. Plans that do not meet the minimum thresholds will have to pay a MLR rebate. For purposes of determining MLR rebates, HHS has defined the types of costs that should be included in the MLR rebate calculation. However, certain components of the MLR calculation as defined by HHS cannot be classified consistently under U.S. generally accepted accounting principles, or GAAP. While considered benefit expense or a reduction of premium revenue by HHS, certain of these costs are classified as other types of expense, such as income tax expense or general and administrative expense, in our GAAP basis financial statements. Accordingly, the benefit expense ratio determined using our consolidated GAAP operating results is not comparable to the MLR calculated under HHS regulations.

Health Care Reform also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D plans beginning in 2014. Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will

be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

Beginning in 2014, Health Care Reform imposed an annual HIP Fee on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount collected from allocations to health insurers was $11,300.0 for each of 2016 and 2015 and $8,000.0 for 2014. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee for 2016, 2015 and 2014 was $1,176.3, $1,207.5 and $893.3, respectively. The annual HIP Fee to be allocated to all health insurers has been suspended for 2017 and is scheduled to resume and be increased to $14,300.0 for 2018, without subsequent legislative or regulatory action. For 2019 and beyond, the annual HIP Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.

These and other provisions of Health Care Reform are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets. We will continue to evaluate the impact of Health Care Reform including any substantial changes to existing laws or regulations that may impact our business. For additional discussion regarding Health Care Reform, see Part I, Item 1 “Business—Regulation” and Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are also subject to regulations that may result in assessments under state insurance guaranty association laws. The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state’s policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. In 2009, the Pennsylvania Insurance Commissioner placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. After failing to develop a viable rehabilitation plan, the Pennsylvania Insurance Commissioner filed a petition to convert the rehabilitation to a liquidation, with the liquidation expected to commence following the coordination of certain scheduling matters. When Penn Treaty is placed in liquidation, we and other insurers will be obligated to pay a portion of their policyholder claims through state guaranty association assessments in future periods. At December 31, 2016, we estimate our portion of the assessments for the Penn Treaty insolvency will approximate $190.0 to $220.0. In accordance with FASB guidance, the ultimate amount of the assessments will be recognized as an expense in the period in which a court ordered liquidation is entered. Payment of the assessments will be largely recovered through premium billing surcharges and premium tax credits over future years.

In addition to the external forces discussed in the preceding paragraphs, our results of operations are impacted by levels and mix of membership. In recent years, we have experienced membership growth due to the quality and pricing of our health benefits products and services, improved economic conditions, decreases in unemployment, acquisitions, entry into new markets and expansions in existing markets. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. However, these membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. Further, our mix of membership may include more individuals with a higher acuity level obtaining coverage through our products available on the public exchanges, which may not be appropriately adjusted for in our premium rates.

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. We have continued to implement security enhancements since this incident. For additional information about the cyber attack, see Note 13, “Commitments and Contingencies - Cyber Attack Incident,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.
Also see Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K, for a discussion of the factors identified above and other risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time.

Executive Summary

We are one of the largest health benefits companies in the United States in terms of medical membership, serving 39.9 medical members through our affiliated health plans as of December 31, 2016. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross (in our New York service areas). We also conduct business through arrangements with other BCBS licensees in South Carolina and Western New York. Through our AMERIGROUP Corporation, or Amerigroup, subsidiary, we conduct business in Florida, Georgia, Iowa, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, and Washington. In addition, we conduct business through our Simply Healthcare Holdings, Inc., or Simply Healthcare, subsidiary in Florida. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with Massachusetts), and in certain Arizona, California, Nevada and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.
On January 31, 2014, we sold our 1-800 CONTACTS, Inc. business and our glasses.com related assets, or collectively, 1-800 CONTACTS. The operating results for 1-800 CONTACTS for the one month ended January 31, 2014 are reported as discontinued operations within the consolidated statements of income included in Part II, Item 8 of this Annual Report on Form 10-K. These results were previously reported in the Commercial and Specialty Business segment. Unless otherwise specified, all financial information disclosed in this MD&A is from continuing operations, other than net income, diluted earnings per share and cash flows. In accordance with FASB guidance, we have elected to not separately disclose net cash provided by or used in operating, investing, and financing activities and the net effect of those cash flows on cash and cash equivalents for discontinued operations during the periods presented. For additional information regarding these transactions, see Note 3, “Business Acquisitions and Divestiture - Divestiture of 1-800 CONTACTS," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.
Operating revenue for the year ended December 31, 2016 was $84,194.0, an increase of $5,789.2, or 7.4%, from the year ended December 31, 2015. The increase in operating revenue was primarily a result of higher premium revenue in both our Government Business and Commercial and Specialty Business segments, and, to a lesser extent, increased administrative fees in our Commercial and Specialty Business segment. These increases were partially offset by lower administrative fees in our Government Business segment.
Net income for the year ended December 31, 2016 was $2,469.8, a decrease of $90.2, or 3.5%, from the year ended December 31, 2015. The decrease in net income was primarily due to lower operating results in our Government Business segment, an increase in transaction costs associated with our pending acquisition of Cigna, a decrease in net earnings from investment activities and an increase in interest expense.
Our diluted earnings per share, or EPS, for the year ended December 31, 2016 was $9.21, a decrease of $0.17, or 1.8%, from the year ended December 31, 2015. Our diluted shares for the year ended December 31, 2016 were 268.1, a decrease of 4.8, or 1.8% compared to the year ended December 31, 2015. The decrease in EPS resulted from the

decrease in net income, partially offset by the impact of a lower number of shares outstanding in 2016.

Operating cash flow for the year ended December 31, 2016 was $3,204.5, or 1.3 times net income. Operating cash flow for the year ended December 31, 2015 was $4,116.0, or 1.6 times net income. The decrease in operating cash flow from 2015 of $911.5 was primarily attributable to an increase in claims payments due to higher medical cost experience and growth in membership. The decrease was further due to the timing of claim reimbursements from our self-insured customers. These decreases were partially offset by an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and growth in membership. The decrease was further offset by an increase in pharmacy rebates received.

Our results of operations discussed throughout this MD&A are determined in accordance with GAAP. We also calculate operating revenue and operating gain to further aid investors in understanding and analyzing our core operating results and comparing them among periods. We define operating revenue as premium income, administrative fees and other revenues. Operating gain is calculated as total operating revenue less benefit expense, and selling, general and administrative expense. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating performance and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For additional details on operating gain, see our “Reportable Segments Results of Operations” discussion included in this MD&A. For a reconciliation of reportable segment operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of reportable segment operating gain to income from continuing operations before income tax expense, see Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We intend to expand through a combination of organic growth, strategic acquisitions, including the pending acquisition of Cigna, and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale as well as providing us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. While we have achieved strong growth as a result of strategic mergers and acquisitions, we have also achieved organic growth in our existing markets over time by delivering excellent service, offering competitively priced products, providing access to high quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Significant Transactions

While Health Care Reform has caused significant changes to the U.S. health care system in recent years, the significant transactions that have occurred over the last three years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Pending acquisition of Cigna;
- Acquisition of Simply Healthcare (2015);
- Board of Directors declaration of dividends on common stock (2014 through February 2017); authorization for repurchases of our common stock (2017 and prior); and debt repurchases and new debt issuance (2015 and prior); and
- Divestiture of 1-800 CONTACTS (2014).

For additional information regarding these transactions, see Note 3, “Business Acquisitions and Divestiture,” Note 12, "Debt" and Note 14, “Capital Stock,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Membership

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to Amerigroup, CareMore and Simply Healthcare members as well as HealthLink and UniCare members predominantly outside of our BCBSA service areas.

- Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes UniCare members and Employer Group Medicare Advantage members, or retired members of Local Group accounts who have selected a Medicare Advantage product. Local Group accounts are generally sold through brokers or consultants working with industry specialists from our in-house sales force and are offered both on and off the public exchanges. Local Group insurance premiums may be based on claims incurred by the group or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, customer service, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability, reputation and our ability to effectively service large complex accounts. Local Group accounted for 38.7%, 39.5% and 40.4% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration. Customer turnover is generally higher with Individual as compared to Local Group. Individual business accounted for 4.2%, 4.3% and 4.8% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- National Accounts generally consist of multi-state employer groups primarily headquartered in an Anthem service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Service area is defined as the geographic area in which we are licensed to sell BCBS products. National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. We believe we have an advantage when competing for very large National Accounts due to the size and breadth of our networks and our ability to access the national provider networks of BCBS companies at their competitive local market rates. In addition, Employer Group Medicare Advantage members related to National Accounts groups are reported as part of National Accounts membership. The Employer Group Medicare Advantage members represent less than 1.0% of National Accounts membership. National Accounts represented 19.4%, 19.1% and 19.1% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Anthem who receive health care services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Anthem controlled BCBSA licensee (i.e., the "home plan"). We perform certain administrative functions for BlueCard® members, for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the average number of BlueCard® claims received per month. BlueCard® host membership accounted for 13.9%, 14.0% and 14.1% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, who have purchased Medicare Supplement benefit coverage, some disabled members under age 65, or members of all ages with end stage renal disease. We also include in the Medicare category members enrolled in our dual eligible Medicare-Medicaid Plans, or MMPs, in the states where we participate. Medicare Supplement policies are sold to Medicare recipients as supplements to the benefits

they receive from the Medicare program. Rates are filed with and in some cases approved by state insurance

departments. Most of the premium for Medicare Advantage is paid directly by the federal government on behalf of the participant who may also be charged a small premium. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare business accounted for 3.6%, 3.7% and 3.7% of our medical members at December 31, 2016, 2015 and 2014, respectively.

- Medicaid membership represents eligible members who receive health care benefits through publicly funded health care programs, including Medicaid, TANF, SPD, LTSS, CHIP and Medicaid expansion programs. Total Medicaid program business accounted for 16.4%, 15.3% and 13.8% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- FEP members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management. FEP business accounted for 3.9%, 4.1% and 4.1% of our medical members at December 31, 2016, 2015 and 2014, respectively.

In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two principal funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain most or all of the financial risk associated with their employees' health care costs. Some self-funded customers choose to purchase stop loss coverage to limit their retained risk.

The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2016, 2015 and 2014. Also included below is other membership by product. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

	December 31			2016 vs. 2015		2015 vs. 2014	
(In thousands)	2016	2015	2014	Change	% Change	Change	% Change
Medical Membership							
Customer Type							
Local Group	15,429	15,241	15,137	188	1.2 %	104	0.7 %
Individual	1,664	1,675	1,793	(11)	(0.7)%	(118)	(6.6)%
National:							
National Accounts	7,741	7,355	7,155	386	5.2 %	200	2.8 %
BlueCard®	5,550	5,407	5,279	143	2.6 %	128	2.4 %
Total National	13,291	12,762	12,434	529	4.1 %	328	2.6 %
Medicare	1,438	1,439	1,404	(1)	(0.1)%	35	2.5 %
Medicaid	6,527	5,914	5,193	613	10.4 %	721	13.9 %
FEP	1,570	1,568	1,538	2	0.1 %	30	2.0 %
Total Medical Membership	39,919	38,599	37,499	1,320	3.4 %	1,100	2.9 %
Funding Arrangement							
Self-Funded	24,688	23,666	22,800	1,022	4.3 %	866	3.8 %
Fully-Insured	15,231	14,933	14,699	298	2.0 %	234	1.6 %
Total Medical Membership	39,919	38,599	37,499	1,320	3.4 %	1,100	2.9 %
Reportable Segment							
Commercial and Specialty Business	30,384	29,678	29,364	706	2.4 %	314	1.1 %
Government Business	9,535	8,921	8,135	614	6.9 %	786	9.7 %
Total Medical Membership	39,919	38,599	37,499	1,320	3.4 %	1,100	2.9 %
Other Membership							
Life and Disability Members	4,732	4,849	4,762	(117)	(2.4)%	87	1.8 %
Dental Members	5,486	5,206	4,995	280	5.4 %	211	4.2 %
Dental Administration Members	5,294	5,282	4,918	12	0.2 %	364	7.4 %
Vision Members	6,388	5,641	5,096	747	13.2 %	545	10.7 %
Medicare Advantage Part D Members	629	622	690	7	1.1 %	(68)	(9.9)%
Medicare Part D Standalone Members	350	371	467	(21)	(5.7)%	(96)	(20.6)%

December 31, 2016 Compared to December 31, 2015

Medical Membership (in thousands)

During the year ended December 31, 2016, total medical membership increased 1,320, or 3.4%, primarily due to increases in our Medicaid, National Accounts, Local Group and BlueCard® membership.

Self-funded medical membership increased 1,022, or 4.3%, primarily due to increases in our National Accounts, Large Group accounts and BlueCard® membership.

Fully-insured membership increased 298, or 2.0%, primarily due to growth in our Medicaid business, partially offset by declines in Local Group fully-insured membership.

Local Group membership increased 188, or 1.2%, primarily due to growth in our Large Group self-funded accounts as a result of new sales and conversions of fully-insured contracts to self-funded administrative service only, or ASO contracts. The increase was partially offset by attrition in our fully-insured product offerings resulting from competitive pressures and conversions to self-funded ASO contracts.

Individual membership decreased 11, or 0.7%, primarily due to attrition in non-ACA-compliant product offerings, partially offset by growth in ACA-compliant off- and on-exchange product offerings.

National Accounts membership increased 386, or 5.2%, primarily due to the implementation of new large multi-state employer group contracts and expansion in existing employer group accounts.

BlueCard® membership increased 143, or 2.6%, primarily due to higher membership activity at other BCBSA plans whose members reside in or travel to our licensed areas.

Medicare membership decreased 1, or 0.1%, primarily due to membership losses from strategic market exits, partially offset by growth in certain existing markets.

Medicaid membership increased 613, or 10.4%, primarily due to new business expansions and organic growth in existing markets.

FEP membership increased 2, or 0.1%, primarily due to higher sales during the open enrollment period.

Other Membership (in thousands)

Our Other products are often ancillary to our health business and can therefore be impacted by corresponding changes in our medical membership.

Life and disability membership decreased 117, or 2.4%, primarily due to higher lapses in our fully-insured Local Group business.

Dental membership increased 280, or 5.4%, primarily due to new sales and growth in our Local Group and ACA-compliant Individual product offerings.

Dental administration membership increased 12, or 0.2%, primarily due to membership expansion under current contracts.

Vision membership increased 747, or 13.2%, primarily due to growth in our Local Group, National accounts and ACA-compliant Individual product offerings.

Medicare Advantage Part D membership increased 7, or 1.1%, primarily due to higher sales during the open enrollment period.

Medicare Part D standalone membership decreased 21, or 5.7%, primarily due to our product repositioning strategies and select strategic actions in certain markets.

December 31, 2015 Compared to December 31, 2014

Medical Membership (in thousands)

During the year ended December 31, 2015, total medical membership increased 1,100, or 2.9%, primarily due to increases in our Medicaid, National Accounts, BlueCard® and Local Group membership, partially offset by decreases in our Individual membership.

Self-funded medical membership increased 866, or 3.8%, primarily due to increases in our Local Group self-funded accounts as a result of new sales and conversions of fully-insured contracts to self-funded ASO contracts, and growth in our National Accounts and BlueCard® membership.

Fully-insured membership increased 234, or 1.6%, primarily due to growth in our Medicaid and Medicare businesses including membership acquired with the acquisition of Simply Healthcare, and increased sales in our Individual business ACA-compliant on- and off-exchange product offerings. These increases were partially offset by Local Group fully-insured membership declines, largely driven by conversions of fully-insured contracts to self-funded ASO contracts and our decision to exit the Georgia employer group Medicare product offering. The increase was further offset by attrition in our Individual business non-ACA-compliant product offerings.

Local Group membership increased 104, or 0.7%, primarily due to increases in our self-funded accounts. The increase in membership was partially offset by attrition in our Small Group line of business resulting from product mix changes as members moved into Health Care Reform product offerings and competitive pressures. The increase was further offset by fully-insured membership declines resulting from our decision to exit the Georgia employer group Medicare product offering.

Individual membership decreased 118, or 6.6%, primarily due to attrition in non-ACA-compliant product offerings, partially offset by increased sales in ACA-compliant on- and off-exchange product offerings.

National Accounts membership increased 200, or 2.8%, primarily due to new sales and in-group change.

BlueCard® membership increased 128, or 2.4%, primarily due to favorable membership activity at other BCBSA plans whose members reside in or travel to our licensed areas.

Medicare membership increased 35, or 2.5%, primarily due to membership acquired through the acquisition of Simply Healthcare and growth in our MMPs primarily due to commencement of operations in new dual eligible markets.

Medicaid membership increased 721, or 13.9%, primarily due to commencement of operations in new markets including membership acquired through the acquisition of Simply Healthcare, and growth through Health Care Reform expansions.

FEP membership increased 30, or 2.0%, primarily due to higher sales during open enrollment.

Other Membership (in thousands)

Our Other products are often ancillary to our health business and can therefore be impacted by corresponding changes in our medical membership.

Life and disability membership increased 87, or 1.8%, primarily due to growth and higher sales in our Local Group business.

Dental membership increased 211, or 4.2%, primarily due to new sales and growth in our Local Group and Individual businesses, partially offset by attrition in our off-exchange Local Group and Individual business product offerings.

Dental administration membership increased 364, or 7.4%, primarily due to the acquisition of a large managed dental contract pursuant to which we provide dental administrative services.

Vision membership increased 545, or 10.7%, primarily due to increased sales and penetration in our Medicare business, and growth in our Local Group, National Accounts and Individual businesses. These increases were partially offset by attrition in our off-exchange Local Group and Individual business product offerings.

Medicare Advantage Part D membership decreased 68, or 9.9%, primarily due to membership declines resulting from our decision to exit the Georgia employer group Medicare product offering, partially offset by commencement of operations in new dual eligible markets and membership acquired through the acquisition of Simply Healthcare.

Medicare Part D standalone membership decreased 96, or 20.6%, primarily due to our product repositioning strategies and select strategic actions in certain markets.

Cost of Care

The following discussion summarizes our aggregate underlying cost of care trends for the year ended December 31, 2016 for our Local Group fully-insured business only.

Our cost of care trends are calculated by comparing the year-over-year change in average per member per month claim costs. While our cost of care trend varies by geographic location, based on underlying medical cost trends, we estimate that our aggregate cost of care trend was in the lower end of the 7.0% to 7.5% range for the full year of 2016. We anticipate that medical cost trends will be in the range of 6.5% to 7.0% in 2017.

Outpatient and professional utilization have been consistent with prior years. Inpatient and pharmacy utilization have been lower than in prior years. Consistent with prior years, provider rate increases were a primary driver of medical cost trends. We continually negotiate with hospitals and physicians to manage these cost trends. We commonly negotiate multi-year contracts with hospitals and physicians, minimizing annual fluctuations in medical cost trend. We remain committed to optimizing our reimbursement rates and strategies to help address the cost pressures faced by employers and consumers. Unit cost increases, as well as increases in high cost specialty drug offerings and usage, were also a driver of pharmacy cost. For example, high cost Hepatitis C drug therapies continued to put upward pressure on pharmacy trend. We have negotiated to lower the cost of these Hepatitis C drug therapies and continue to review clinical appropriateness of these new Hepatitis C drug therapies to ensure members receive the most appropriate treatment and length of therapy.

In response to cost trends, we continue to pursue contracting and plan design changes, promote and implement performance-based contracts that reward clinical outcomes and quality, and expand care management programs. We are taking a leadership role in the area of payment reform as evidenced by our Enhanced Personal Health Care program. By establishing the primary care doctor as central to the coordination of a patient's health care needs, the initiative builds on the success of current patient-centered medical home programs in helping to improve patient care while lowering costs.

A number of clinical management initiatives are in place to help mitigate inpatient trend. Focused review efforts continue in key areas, including targeting outlier facilities for length of stay and readmission, and high risk maternity and neonatal intensive care unit cases, as noted below. Additionally, we continue to refine our programs related to readmission management, focused behavioral health readmission reduction and post-discharge follow-up care.

- Neonatal Intensive Care Unit Focused Review - Collaborative teams focus on developing a comprehensive plan of care and safe and effective discharge planning so that individuals can be released from the Neonatal Intensive Care Unit as soon as medically appropriate.

Outpatient costs are a collection of different types of expenses, such as outpatient facilities, labs, x-rays, emergency room, occupational and physical therapy and many others. Example programs developed to mitigate outpatient costs are as follows:

- Cancer Care Quality Program - This program, developed in collaboration with our subsidiary AIM Specialty Health, identifies certain cancer treatment pathways selected based upon current medical evidence, peer-reviewed published literature, consensus guidelines and our clinical policies to support oncologists in identifying cancer treatment therapies that are highly effective and provide greater value.
- Avoidable Emergency Room Visits - This program seeks to help educate members and providers about potentially avoidable emergency room visits. Phone calls and mailings are used to inform members of alternate sites of care, such as primary care physicians, urgent care facilities, and walk-in doctor's offices that can replace visits to the emergency room in certain situations.
- Specialty Drug Site of Care - This program, when clinically appropriate and safe, uses clinical site of care review to encourage utilization of certain specialty drugs in more effective settings such as physician offices, ambulatory infusion suites and in the home using home infusion therapy.
- Fraud and Abuse - This program, through investigation and identification of providers with an invalid medical license and/or expired prescribing privileges, seeks to prevent improper payment of medical or pharmacy claims.

Consolidated Results of Operations

Our consolidated summarized results of operations for the years ended December 31, 2016, 2015 and 2014 are discussed in the following section.

	Years Ended December 31			Change 2016 vs. 2015		2015 vs. 2014	
	2016	2015	2014	$	%	$	%
Total operating revenue	$84,104.0	$78,404.8	$73,021.7	$5,789.2	7.4 %	$5,383.1	7.4 %
Net investment income	779.5	677.6	724.4	101.9	15.0 %	(46.8)	(6.5)%
Net realized gains on financial instruments	4.9	157.5	177.0	(152.6)	(96.9)%	(19.5)	(11.0)%
Other-than-temporary impairment losses on investments	(115.4)	(83.4)	(49.0)	(32.0)	(38.4)%	(34.4)	(70.2)%
Total revenues	84,863.0	79,156.5	73,874.1	5,706.5	7.2 %	5,282.4	7.2 %
Benefit expense	66,834.4	61,116.9	56,854.9	5,717.5	9.4 %	4,262.0	7.5 %
Selling, general and administrative expense	12,557.9	12,534.8	11,748.4	23.1	0.2 %	786.4	6.7 %
Other expense[1]	915.3	873.8	902.7	41.5	4.7 %	(28.9)	(3.2)%
Total expenses	80,307.6	74,525.5	69,506.0	5,782.1	7.8 %	5,019.5	7.2 %
Income from continuing operations before income tax expense	4,555.4	4,631.0	4,368.1	(75.6)	(1.6)%	262.9	6.0 %
Income tax expense	2,085.6	2,071.0	1,808.0	14.6	0.7 %	263.0	14.5 %
Income from continuing	2,469.8	2,560.0	2,560.1	(90.2)	(3.5)%	(0.1)	— %

operations							
Income from discontinued operations, net of tax[2]	—	9.6	—	NM[3]	(9.6)	NM[3]	
Net income	$2,469.8	$2,560.0	$2,569.7	$(90.2)	(3.5)%	$(9.7)	(0.4)%
Average diluted shares outstanding	268.1	272.9	285.9	(4.8)	(1.8)%	(13.0)	(4.5)%
Diluted net income per share:							
Diluted - continuing operations	$9.21	$9.38	$8.96	$(0.17)	(1.8)%	$0.42	4.7%
Diluted - discontinued operations[2]	—	—	0.03	—	NM[3]	(0.03)	NM[3]
Diluted net income per share	$9.21	$9.38	$8.99	$(0.17)	(1.8)%	$0.39	4.3%
Benefit expense ratio[4]	84.8%	83.3%	83.1%		150bp[5]		20bp[5]
Selling, general and administrative expense ratio[6]	14.9%	16.0%	16.1%		(110)bp[5]		(10)bp[5]
Income from continuing operations before income taxes as a	5.4%	5.9%	5.9%		(50)bp[5]		0bp[5]

percentage of total revenue					
Net income as a percentage of total revenue	2.9 %	3.2 %	3.5 %	(30)bp[5]	(30)bp[5]

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

1 Includes interest expense, amortization of other intangible assets and gain/loss on extinguishment of debt.

2 The operating results of 1-800 CONTACTS are reported as discontinued operations as a result of the divestiture completed on January 31, 2014.

3 Calculation not meaningful.

4 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2016, 2015 and 2014 were $78,860.1, $73,385.1 and $68,389.8, respectively. Premiums are included in total operating revenue presented above.

5 bp = basis point; one hundred basis points = 1%.

6 Selling, general and administrative expense ratio represents selling, general and administrative expense as a percentage of total operating revenue.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Total operating revenue increased $5,789.2, or 7.4%, to $84,194.0 in 2016, resulting primarily from higher premiums, and, to a lesser extent, increased administrative fees. Higher premiums were largely due to rate increases across our businesses designed to cover overall cost trends. The increase was further attributable to membership increases in our Medicaid and ACA-compliant off- and on-exchange Individual business product offerings. Additionally, adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program and increased reimbursed benefit utilization in our FEP business contributed to the increase in premiums. The increase in premiums was partially offset by the declines in fully-insured membership in our Small Group business and lapses in non-ACA-compliant Individual business product offerings. The increase in administrative fees primarily resulted from membership growth and rate increases for self-funded members in our National Accounts and Large Group businesses.

Net investment income increased $101.9, or 15.0%, to $779.5 in 2016, primarily due to higher income from alternative investments.

Net realized gains on financial instruments decreased $152.6, or 96.9%, to $4.9 in 2016, primarily due to an increase in net realized losses on derivative financial instruments, largely as a result of losses recognized on options entered in to economically hedge the variability of cash flows in the interest payments on anticipated future financings. The decrease was further due to lower net realized gains on sales of equity securities. These decreases were partially offset by an increase in net realized gains on sales of fixed maturity securities.

Other-than-temporary impairment losses on investments increased $32.0, or 38.4%, to $115.4 in 2016, primarily due to an increase in impairment losses on fixed maturity securities, partially offset by a decrease in impairment losses on equity securities.

Benefit expense increased $5,717.5, or 9.4%, to $66,834.4 in 2016, primarily due to increased costs as a result of overall cost trends across our businesses. The increase was further attributable to membership growth in our Medicaid business and ACA-compliant off- and on-exchange Individual business product offerings. These increases were partially offset by the declines in fully-insured membership in our Small Group business and non-ACA-compliant Individual business product offerings.

Our benefit expense ratio increased 150 basis points to 84.8% in 2016. The increase in the ratio was largely driven by our Medicaid business due to increases in medical cost experience that exceeded the impact of premium rate adjustments, higher than expected medical cost experience in the Iowa market, which we began serving in 2016, and increases in membership as our Medicaid business has a higher benefit expense ratio than our consolidated average. The increase in the ratio was further due to higher medical costs experience in our Individual and Local Group businesses. These increases were partially offset by adjustments to estimates of prior year accruals related to the Health Care Reform risk adjustment premium stabilization program and improved medical cost performance in our Medicare business.

Selling, general and administrative expense was $12,557.9 and $12,534.8 in 2016 and 2015, respectively. Our selling, general and administrative expense ratio decreased 110 basis points to 14.9% in 2016. The decrease in the ratio was primarily a result of lower costs related to expense efficiency initiatives and the increase in operating revenue, including the impact of Medicaid membership growth in our Government Business segment, which has a lower selling, general and administrative expense ratio than our consolidated average.

Other expense increased $41.5, or 4.7%, to $915.3 in 2016, primarily due to higher interest expense in 2016 driven by amortization of the fees incurred for the bridge facility commitment letter and joinder agreement entered into during the third quarter of 2015 to partially fund the pending acquisition of Cigna. The increase in interest expense was partially offset by a decrease in amortization of intangible assets.

Income tax expense increased $14.6, or 0.7%, to $2,085.6 in 2016. The effective tax rates in 2016 and 2015 were 45.8% and 44.7%, respectively. The increase in income tax expense and the effective tax rate was primarily due to the increase in non-deductible costs incurred associated with the pending acquisition of Cigna and the increase in our California deferred state tax expense resulting from recent California legislation related to Managed Care Organizations. The increase was further due to favorable 2015 tax adjustments related to state audit settlements. These increases were partially offset by the

non-recurring impact of an adverse California franchise tax ruling recognized in 2015 and a decrease in income before income tax expense.

Our net income as a percentage of total revenue decreased 30 basis points to 2.9% in 2016 as compared to 2015 as a result of all factors discussed above.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

Total operating revenue increased $5,383.1, or 7.4% to $78,404.8 in 2015, resulting primarily from higher premiums, and, to a lesser extent, increased administrative fees. Higher premiums were mainly due to membership increases across our Government Business segment, including membership obtained through the acquisition of Simply Healthcare, and rate increases across our businesses designed to cover overall cost trends and the increase in the HIP Fee. The increase in premiums was further attributable to membership increases in our ACA-compliant on- and off-exchange Individual business product offerings and refinement of estimates associated with Medicare risk score revenue in the prior year. The increase in premiums was offset, in part, by the fully-insured membership declines in our Local Group business, attrition in non-ACA-compliant Individual business product offerings and adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program. The increase in administrative fees primarily resulted from rate increases and membership growth for self-funded members in our Local Group and National Accounts businesses.

Net investment income decreased $46.8, or 6.5%, to $677.6 in 2015, primarily due to lower income from alternative investments, partially offset by higher investment yields on fixed maturity securities.

Net realized gains on financial instruments decreased $19.5, or 11.0%, to $157.5 in 2015, primarily due to an increase in net realized losses on sales of fixed maturity securities, partially offset by an increase in net realized gains on sales of equity securities and settlements of derivative financial instruments.

Other-than-temporary impairment losses on investments increased $34.4, or 70.2%, to $83.4 in 2015, primarily due to an increase in impairment losses on equity and fixed maturity securities.

Benefit expense increased $4,262.0, or 7.5%, to $61,116.9 in 2015, primarily due to increase in overall cost trends across our businesses, membership growth across our Government Business segment, including membership obtained through the acquisition of Simply Healthcare, and membership growth in our ACA-compliant on- and off-exchange Individual business product offerings. These increases were partially offset by the fully-insured membership declines in our Local Group business and non-ACA-compliant Individual business product offerings, as described above.

Our benefit expense ratio increased 20 basis points to 83.3% in 2015, largely driven by changes in the mix of the product portfolio, higher than expected medical costs in our Individual business, and adjustments to accruals related to the Health Care Reform risk adjustment premium stabilization program. These increases were partially offset by improvement in our Local Group business and certain Medicare lines of business predominantly due to improved medical cost performance. The increase in the ratio was further offset by refinement of estimates associated with Medicare risk score revenue in the prior year.

Selling, general and administrative expense increased $786.4, or 6.7%, to $12,534.8 in 2015. Our selling, general and administrative expense ratio decreased 10 basis points to 16.0% in 2015. The increase in the expense was primarily due to increased associate costs to support our growth in membership. The increase in expense was further due to net increases in Health Care Reform fees, primarily due to an increase in the HIP Fee of $314.2, and increased premium taxes as a result of the growth in premiums. These increases were partially offset by a decrease in assessments related to the Health Care Reform reinsurance premium stabilization program of $163.4. The decrease in the ratio was primarily due to the impact of Medicaid membership growth in our Government Business segment, which has a lower selling, general and administrative expense ratio than our consolidated average.

Other expense decreased $28.9, or 3.2%, to $873.8 in 2015, primarily due to changes in gains and losses on the extinguishment of debt. For the year ended December 31, 2015, we recognized net gains on extinguishment of debt of $9.3 compared to net losses on extinguishment of debt of $81.1 for the year ended December 31, 2014. The decrease in other expense was partially offset by higher interest expense in 2015 driven by higher outstanding debt balances and the amortization of fees incurred for the obtainment of the bridge facility commitment letter and joinder agreement to partially

fund the pending acquisition of Cigna. The decrease in other expense was further offset by an increase in amortization of intangible assets. For additional information related to our borrowings, see "Liquidity and Capital Resources - Debt," below.

Income tax expense increased $263.0, or 14.5%, to $2,071.0 in 2015. The effective tax rates in 2015 and 2014 were 44.7% and 41.4%, respectively. The increase in income tax expense was primarily due to the increase of the non-tax deductible HIP Fee, increased income before income taxes and increased state tax expense as a result of an adverse California franchise tax ruling. The increase in the effective tax rate for 2015 was primarily due to the increase in the non-tax deductible HIP fee and the state tax impact of the adverse California franchise tax ruling.

Our net income as a percentage of total revenue decreased 30 basis points to 3.2% in 2015 as compared to 2014 as a result of all factors discussed above.

Reportable Segments Results of Operations

We use operating gain to evaluate the performance of our reportable segments, which are Commercial and Specialty Business; Government Business; and Other. Operating gain is calculated as total operating revenue less benefit expense and selling, general and administrative expense. It does not include net investment income, net realized gains on financial instruments, other-than-temporary impairment losses recognized in income, interest expense, amortization of other intangible assets, (gain) loss on extinguishment of debt or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management. The discussion of segment results for the years ended December 31, 2016, 2015 and 2014 presented below are based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definitions of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. For additional information, see Note 19, “Segment Information,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Our Commercial and Specialty Business, Government Business, and Other segments’ summarized results of operations for the years ended December 31, 2016, 2015 and 2014 are as follows:

	Years Ended December 31			Change			
				2016 vs. 2015		2015 vs. 2014	
	2016	2015	2014	$	%	$	%
Commercial and Specialty Business							
Operating revenue	$38,692.1	$37,570.8	$39,199.6	$1,121.3	3.0 %	$(1,628.8)	(4.2)%
Operating gain	$3,195.2	$2,854.0	$3,260.9	$341.2	12.0 %	$(406.9)	(12.5)%
Operating margin	8.3 %	7.6 %	8.3 %		70 bp		(70)bp
Government Business							
Operating revenue	$45,477.7	$40,813.0	$33,796.4	$4,664.7	11.4 %	$7,016.6	20.8 %
Operating gain	$1,784.3	$1,978.5	$1,191.9	$(194.2)	(9.8)%	$786.6	66.0 %
Operating margin	3.9 %	4.8 %	3.5 %		(90)bp		130 bp
Other							
Operating revenue[1]	$24.2	$21.0	$25.7	$3.2	15.2 %	$(4.7)	(18.3)%
Operating loss[2]	$(177.8)	$(79.4)	$(34.4)	$(98.4)	123.9 %	$(45.0)	130.8 %

1 Fluctuations not material.

2 Fluctuations are primarily a result of changes in unallocated corporate expenses. The increases in 2016 and 2015 were primarily due to transaction costs associated with our pending acquisition of Cigna.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Commercial and Specialty Business

Operating revenue increased $1,121.3, or 3.0%, to $38,692.1 in 2016, primarily due to premium rate increases designed to cover overall cost trends in our Local Group and Individual businesses. The increase was further attributable to adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program, membership growth in our ACA-compliant off- and on-exchange Individual business product offerings and increased administrative fees. The increase in administrative fees was primarily due to membership growth and rate increases for self-funded members in our National Accounts and self-funded Large Group businesses. The increase in operating revenue was partially offset by declines in fully-insured membership in our Small Group business and lapses in non-ACA-compliant Individual business product offerings.

Operating gain increased $341.2, or 12.0%, to $3,195.2 in 2016, primarily due to adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program and lower selling, general and administrative expense related to expense efficiency initiatives. The increase was further attributable to membership growth in our National Accounts and self-funded Large Group businesses. These increases were partially offset by higher medical cost experience in our Individual and Local Group businesses and decreases in fully-insured Small Group membership.

The operating margin in 2016 was 8.3%, a 70 basis point increase over 2015, primarily due to the factors discussed in the preceding two paragraphs.

Government Business

Operating revenue increased $4,664.7, or 11.4%, to $45,477.7 in 2016. The increase in operating revenue was primarily due to increased premiums in our Medicaid business as a result of membership growth through new business expansions and organic growth in existing markets. The increase in operating revenue was also due to rate increases designed to cover overall cost trends in our Medicaid and Medicare businesses and increased premiums in our FEP business, due to increased reimbursed benefit utilization.

Operating gain decreased $194.2, or 9.8%, to $1,784.3 in 2016, primarily due to increases in medical cost experience in our Medicaid business that exceeded the impact of premium rate adjustments and higher than expected medical cost experience in the Iowa Medicaid market, which we began serving in 2016. These decreases were partially offset by lower selling, general and administrative expense related to expense efficiency initiatives, improved medical cost performance in our Medicare business and the favorable impact of a retroactive change in the minimum MLR calculation under California's Medicaid expansion program.

The operating margin in 2016 was 3.9%, a 90 basis point decrease from 2015, primarily due to the factors discussed in the preceding two paragraphs.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

Commercial and Specialty Business

Operating revenue decreased $1,628.8, or 4.2%, to $37,570.8 in 2015, due in part to fully-insured membership declines in our Large Group business largely driven by the discontinuation of our Georgia employer group Medicare product offering. The decrease in operating revenue was further attributable to attrition in our Small Group line of business resulting from both product mix changes as members moved into Health Care Reform product offerings and competitive pressures. Additionally, operating revenue decreased as a result of attrition in non-ACA-compliant Individual business product offerings and adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program. These decreases were partially offset by premium rate increases in our Individual and Local Group lines of business designed to cover overall cost trends and the increase in the HIP Fee. The decrease in operating revenue was further offset by membership growth in our ACA-compliant on- and off-exchange Individual business product offerings and increased administrative fees. The increase in administrative fees was primarily attributable to membership growth and rate increases for self-funded members in our Large Group and National Accounts businesses.

Operating gain decreased $406.9, or 12.5%, to $2,854.0 in 2015, primarily due to higher than expected medical costs in our Individual business, membership declines in our fully-insured Local Group and Individual lines of business and adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program. These decreases were partially offset by an increase in operating gain in our Local Group business primarily due to improved medical cost performance. The increase in operating gain was further offset by increases in self-funded membership in our Local Group and National Accounts businesses.

The operating margin in 2015 was 7.6%, a 70 basis point decrease from 2014, primarily due to the factors discussed in the preceding two paragraphs.

Government Business

Operating revenue increased $7,016.6, or 20.8%, to $40,813 in 2015. The increase in operating revenue was primarily due to increased premiums in our Medicaid business as a result of membership growth through commencement of operations in new markets including membership obtained through the acquisition of Simply Healthcare, membership growth through Health Care Reform expansions and membership growth in existing markets. The increase in Medicaid premiums was further due to rate increases designed to cover overall cost trends and the increase in the HIP Fee. The increase in operating revenue was further attributable to premium increases in our Medicare business as a result of rate increases designed to cover overall cost trends, the acquisition of Simply Healthcare and refinement of estimates associated with Medicare risk score revenue in the prior year. Finally, increased premiums in our FEP business primarily due to increased benefit utilization contributed to the increase in operating revenue.

Operating gain increased $786.6, or 66.0%, to $1,978.5 in 2015, primarily due to membership growth and improved medical cost performance in certain markets in our Medicaid and Medicare business, and refinement of estimates associated with Medicare risk score revenue in the prior year that did not recur in the current year. The increase in operating gain was further attributable to higher reimbursements for the non-tax deductible portion of the HIP Fee. These increases were partially offset by higher administrative costs to support our growth in membership.

The operating margin in 2015 was 4.8%, a 130 basis point increase over 2014, primarily due to the factors discussed in the preceding two paragraphs.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our other significant accounting policies are summarized in Note 2, “Basis of Presentation and Significant Accounting Policies,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third party professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2016, this liability was $7,892.6 and represented 19.7% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 96.5%, or $7,619.9, of our total medical claims liability as of December 31, 2016; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 3.5%, or $272.7, of the total medical claims payable as of December 31, 2016. The level of claims payable processed through our systems but not yet paid may fluctuate from one period end to the next, from approximately 1% to 5% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim payments. This information is analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims. For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather they are projected by estimating the claims expense for those months based on recent claims expense levels and health care trend levels, or "trend factors."

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison of prior year, the methods and assumptions are not changed as reserves are recalculated; rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of health care costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary's judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2016 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2016, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 2%, or approximately $178.0, in the December 31, 2016 incurred but not paid claims liability, depending on the completion

factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2016 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2016, there was a 320 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 5%, or approximately $359.0, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2016.

See Note 11, “Medical Claims Payable,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2016, 2015 and 2014. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 11, “Medical Claims Payable,” the line labeled “Net incurred medical claims: Prior years redundancies” accounts for those adjustments made to prior year estimates. The impact of any reduction of “Net incurred medical claims: Prior years redundancies” may be offset as we establish the estimate of “Net incurred medical claims: Current year.” Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 89.1% for both 2016 and 2015 and 89.4% for 2014. This ratio serves as an indicator of claims processing speed whereby claims were processed at the same speed in 2016 and 2015. The decrease in the ratio in 2015 from 2014 reflects a decrease in claims processing speed.

We calculate the percentage of prior years’ redundancies in the current year as a percent of prior years' net incurred claims payable less prior years’ redundancies in the current year in order to demonstrate the development of the prior years’ reserves. This metric was 14.0% for the year ended December 31, 2016, 15.1% for the year ended December 31, 2015 and 9.7% for the year ended December 31, 2014. The year ended December 31, 2016 metric reflects a slightly lower level of conservatism than the metric for the year ended December 31, 2015. The year ended December 31, 2015 metric reflects a higher level of conservatism than the metric for year ended December 31, 2014.

We calculate the percentage of prior years’ redundancies in the current period as a percent of prior years’ net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the year ended December 31, 2016, this metric was 1.4%, which was calculated using the redundancy of $850.4. This metric was 1.4% for 2015 and 1.0% for 2014.

The following table shows the variance between total net incurred medical claims as reported in Note 11, “Medical Claims Payable,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, for each of 2015 and 2014 and the incurred claims for such years had it been determined retrospectively (computed as the difference between “net incurred medical claims – current year” for the year shown and “net incurred medical claims – prior years redundancies” for the immediately following year):

	Years Ended December 31	
	2015	2014
Total net incurred medical claims, as reported	$59,908.2	$55,763.9
Retrospective basis, as described above	59,858.0	55,505.6
Variance	$50.2	$258.3
Variance to total net incurred medical claims, as reported	0.1 %	0.5 %

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2016 estimate of medical claims payable will be known during 2017.

The 2015 variance to total net incurred medical claims, as reported of 0.1% was lower than the 2014 percentage of 0.5%. The lower 2015 variance was driven by a higher level of incurred claims recognized in 2015 as compared to 2014, with an approximately similar level of prior year redundancies recognized in each of the subsequent years.

Income Taxes

We account for income taxes in accordance with FASB guidance, which requires, among other things, the separate recognition of deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. A valuation allowance must be established for deferred tax assets if it is "more likely than not" that all or a portion may be unrealized. Our judgment is required in determining an appropriate valuation allowance.

At each financial reporting date, we assess the adequacy of the valuation allowance by evaluating each of our deferred tax assets based on the following:

- the types of temporary differences that created the deferred tax asset;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

We, like other companies, frequently face challenges from tax authorities regarding the amount of taxes due. These challenges include questions regarding the timing and amount of deductions that we have taken on our tax returns. In evaluating any additional tax liability associated with various positions taken in our tax return filings, we record additional liabilities for potential adverse tax outcomes. Based on our evaluation of our tax positions, we believe we have appropriately accrued for uncertain tax benefits, as required by the guidance. To the extent we prevail in matters we have accrued for, our future effective tax rate would be reduced and net income would increase. If we are required to pay more than accrued, our future effective tax rate would increase and net income would decrease. Our effective tax rate and net income in any given future period could be materially impacted.

In the ordinary course of business, we are regularly audited by federal and other tax authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law and we intend to defend our positions vigorously through the federal, state and local appeals processes. We believe we have adequately provided for any reasonable foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact on our results of operations from these matters.

For additional information, see Note 7, "Income Taxes," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2016 was $17,561.2 and other intangible assets were $7,964.9. The sum of goodwill and other intangible assets represented 39.2% of our total consolidated assets and 101.7% of our consolidated shareholders' equity at December 31, 2016.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test.

Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur.

Fair value is estimated using the income and market approaches for goodwill at the reporting unit level and the income approach for our indefinite lived intangible assets. Use of the income and market approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry's weighted-average cost of capital. Market valuations are based on observed multiples of certain measures including revenue, EBITDA (earnings before interest, taxes, depreciation and amortization), and book value of invested capital (debt and equity) and include market comparisons to publicly traded companies in our industry.

We did not incur any impairment losses as a result of our 2016 annual impairment tests as the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2016. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months. However, as a result of certain provisions of Health Care Reform, along with current economic conditions, we have experienced lower operating margins in certain lines of business. Those margins could become further compressed with adverse changes in federal and state laws and regulations. As a result, the estimated fair values of certain of our reporting units with goodwill could fall below their carrying values in future periods and if that were to occur, we would be required to record impairment losses at that time.

While we believe we have appropriately allocated the purchase price of our acquisitions, this allocation requires many assumptions to be made regarding the fair value of assets and liabilities acquired. In addition, estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, "Business Acquisitions and Divestiture" and Note 9, "Goodwill and Other Intangible Assets," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Investments

Current and long-term available-for-sale investment securities were $19,187.4 at December 31, 2016 and represented 29.5% of our total consolidated assets at December 31, 2016. We classify fixed maturity and equity securities in our investment portfolio as "available-for-sale" or "trading" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

We review investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which a security's market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. In addition, for equity securities, we determine whether we have the intent and ability to hold the security for a period of time to allow for a

recovery of its fair value above its carrying amount. If any declines of equity securities are determined to be other-than-temporary, we charge the losses to income when that determination is made.

Certain FASB other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other debt securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default.

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. The current economic environment and volatility of securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets.

We believe we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. However, over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in other-than-temporary impairment losses on investments being charged against future income. Given the current market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and additional, material other-than-temporary impairment losses on investments may be recorded in future periods.

In addition to available-for-sale investment securities, we held additional long-term investments of $2,240.5, or 3.4% of total consolidated assets, at December 31, 2016. These long-term investments consisted primarily of certain other equity investments, cash surrender value of corporate-owned life insurance policies and real estate. Due to their less liquid nature, these investments are classified as long-term.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage the market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future earnings and financial position. Our investment portfolio includes fixed maturity securities with a fair value of $17,687.5 at December 31, 2016. The weighted-average credit rating of these securities was “A” as of December 31, 2016. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions and investments in mortgage-backed securities of $1,301.4 and $1.8, respectively, that are guaranteed by third parties. With the exception of eighteen securities with a fair value of $7.2, these securities are all investment-grade and carry a weighted-average credit rating of “A” as of December 31, 2016. The securities are guaranteed by a number of different guarantors and we do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of the fixed maturity securities without a guarantee, for which such information is available, was “A” as of December 31, 2016.

Fair values of available-for-sale fixed maturity and equity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value in accordance with FASB guidance for fair value measurements and disclosures. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

We obtain only one quoted price for each security from the pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform monthly analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of month-to-month price fluctuations. If unusual fluctuations are noted in this review, we may obtain additional information from other pricing services to validate the quoted price. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2016 and 2015.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2016 totaled $481.4 and represented approximately 2.3% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities, equity securities and structured securities for which observable inputs were not always available and the fair values of these securities were estimated using internal estimates for inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A "Quantitative and Qualitative Disclosures about Market Risk," and Part II, Item 8, Note 2, "Basis of Presentation and Significant Accounting Policies," Note 4, "Investments," and Note 6, "Fair Value," to our audited consolidated financial statements included in this Annual Report on Form 10-K.

Retirement Benefits

Pension Benefits

We sponsor defined benefit pension plans for some of our employees. These plans are accounted for in accordance with FASB guidance for retirement benefits, which requires that amounts recognized in financial statements be determined on an actuarial basis. As permitted by the guidance, we calculate the value of plan assets as described below. Further, the difference between our expected rate of return and the actual performance of plan assets, as well as certain changes in pension liabilities, are amortized over future periods.

An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our December 31, 2016 measurement date, we selected a weighted-average long-term rate of return on plan assets of 7.95%. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and an average of historical returns are also reviewed for appropriateness of the selected assumption. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

This assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is included in the determination of pension expense. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the

workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. At the December 31, 2016 measurement date, the selected weighted-average discount rate was 3.77%, compared to 3.92% at the December 31, 2015 measurement date. We developed this rate using a yield curve approach. Using yields available on high-quality fixed maturity securities with various maturity dates, the yield curve approach provides a "customized" rate, which is meant to match the expected cash flows of our specific benefit plans. The net effect of changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FASB guidance.

In managing the plan assets, our objective is to be a responsible fiduciary while minimizing financial risk. Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. In addition to producing a reasonable return, the investment strategy seeks to minimize the volatility in our expense and cash flow.

Other Postretirement Benefits

We provide most associates with certain medical, vision and dental benefits upon retirement. We use various actuarial assumptions, including a discount rate and the expected trend in health care costs, to estimate the costs and benefit obligations for our retiree benefits.

At our December 31, 2016 measurement date, the selected discount rate for all plans was 3.82%, compared to a discount rate of 4.01% at the December 31, 2015 measurement date. We developed this rate using a yield curve approach as described above.

The assumed health care cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2016 measurement date was 8.00% for 2017 with a gradual decline to 4.50% by the year 2028. The assumed health care cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2016 measurement date was 6.00% for 2017 with a gradual decline to 4.50% by the year 2024. These estimated trend rates are subject to change in the future. The health care cost trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2016 by $42.2 and would increase service and interest costs by $1.8. Conversely, a decrease in the assumed health care cost trend rate of one percentage point would decrease the postretirement benefit obligation as of December 31, 2016 by $36.2 and would decrease service and interest costs by $1.5.

For additional information regarding our retirement benefits, see Note 10, "Retirement Benefits," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2016 that had, or are expected to have a material impact on our financial position, results of operations or financial statement disclosures, see the "Recently Adopted Accounting Guidance" and "Recent Accounting Guidance Not Yet Adopted" sections of Note 2, "Basis of Presentation and Significant Accounting Policies" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Liquidity and Capital Resources

Introduction

Our cash receipts result primarily from premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases

of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

We manage our cash, investments and capital structure so we are able to meet the short and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near term obligations in longer term marketable fixed maturity securities to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Our subsidiaries pay out excess capital annually in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

The availability of financing in the form of debt or equity is influenced by many factors including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have in the past experienced higher than normal volatility, although current market conditions are more stable. During recent years, the federal government and various governmental agencies have taken a number of steps to restore liquidity in the financial markets and to help relieve the credit crisis and strengthen the regulation of the financial services market. In addition, governments around the world have developed their own plans to provide liquidity and security in the credit markets and to ensure adequate capital in certain financial institutions.

We have a $2,500.0 commercial paper program. Should commercial paper issuance be unavailable, we have the ability to use a combination of cash on hand and/or our $3,500.0 senior revolving credit facility to redeem any outstanding commercial paper upon maturity. Additionally, we believe the lenders participating in our credit facility would be willing and able to provide financing in accordance with their legal obligations. In addition to the $3,500.0 senior revolving credit facility, we estimate that we will receive approximately $1,900.0 of dividends from our subsidiaries during 2017, which also provides further operating and financial flexibility.

The table below outlines the cash flows provided by or used in operating, investing and financing activities for the years ended December 31, 2016, 2015 and 2014:

	Years Ended December 31		
	2016	2015	2014
Cash flows provided by (used in):			
Operating activities	$3,204.5	$4,116.0	$3,369.3
Investing activities	(513.9)	(1,151.5)	(974.9)
Financing activities	(732.9)	(2,997.4)	(1,822.5)
Effect of foreign exchange rates on cash and cash equivalents	4.1	(5.3)	(7.1)
Increase (decrease) in cash and cash equivalents	$1,961.8	$(38.2)	$564.8

Liquidity—Year Ended December 31, 2016 Compared to Year Ended December 31, 2015

During the year ended December 31, 2016, net cash flow provided by operating activities was $3,204.5, compared to $4,116.0 for the year ended December 31, 2015, a decrease of $911.5. The decrease was primarily attributable to an increase in claims payments due to higher medical cost experience and growth in membership. The decrease was further due to the timing of claim reimbursements from our self-insured customers. These decreases were partially offset by an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and growth in membership. The decrease was further offset by an increase in pharmacy rebates received.

Net cash flow used in investing activities was $513.9 during the year ended December 31, 2016, compared to $1,151.5 for the year ended December 31, 2015. The decrease in cash flow used in investing activities of $637.6 was primarily due to a

decrease in cash used for the purchase of subsidiaries, as net cash used in investing activities during the year ended December 31, 2015 included the purchase of Simply Healthcare while there were no purchases of subsidiaries during the year ended December 31, 2016. This decrease was partially offset by an increase in net purchases of investments.

Net cash flow used in financing activities was $732.9 during the year ended December 31, 2016, compared to $2,997.4 for the year ended December 31, 2015. The decrease in cash flow used in financing activities of $2,264.5 primarily resulted from a decrease in common stock repurchases, as we did not repurchase any common stock during the year ended December 31, 2016. The decrease was further due to a decrease in net repayments of short- and long-term borrowings and changes in bank overdrafts. The decrease in cash flow used in financing activities was partially offset by changes in commercial paper borrowings, payments on debt-related derivatives in 2016, a decrease in proceeds from the issuance of common stock under our employee stock plans and a decrease in excess tax benefits from share-based compensation.

Liquidity— Year Ended December 31, 2015 Compared to Year Ended December 31, 2014

During the year ended December 31, 2015, net cash flow provided by operating activities was $4,116.0, compared to $3,369.3 for the year ended December 31, 2014, an increase of $746.7. The increase was primarily attributable to an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and the HIP Fee, and growth in membership. The increase in cash provided by operating activities was further attributable to the receipt of the reinsurance recoveries payment related to the 2014 Health Care Reform reinsurance premium stabilization program and payments made in 2014 that did not recur in 2015 for the adjudication of claims relating to the New York State contract conversion from our fully-insured Local Group business to a self-funded ASO contract. The increase in cash provided by operating activities was partially offset by an increase in claims payments, primarily as a result of membership growth, an increase in income tax payments and an increase in the annual HIP Fee payment.

Net cash flow used in investing activities was $1,151.5 during the year ended December 31, 2015, compared to $974.9 for the year ended December 31, 2014. The increase in cash flow used in investing activities of $176.6 primarily resulted from changes in cash flows relating to the purchase and sale of subsidiaries. Cash utilized for the purchase of subsidiaries during the year ended December 31, 2015 primarily related to the purchase of Simply Healthcare. During the year ended December 31, 2014, cash was provided by the sale of our 1-800 CONTACTS business and glasses.com related assets. The increase in cash flow used in investing activities was partially offset by changes in securities lending collateral and a decrease in net purchases of investments.

Net cash flow used in financing activities was $2,997.4 during the year ended December 31, 2015, compared to $1,822.5 for the year ended December 31, 2014. The increase in cash flow used in financing activities of $1,174.9 primarily resulted from changes in long-term borrowings as a result of net repayments of long-term borrowings during 2015 compared to net proceeds from long-term borrowings during 2014. The increase in cash flow used in financing activities was further attributable to changes in securities lending payable, changes in bank overdrafts, an increase in cash dividends paid to shareholders and a decrease in proceeds from the issuance of common stock under our employee stock plans. The increase in cash flow used in financing activities was partially offset by a decrease in common stock repurchases, an increase in net proceeds from commercial paper borrowings, an increase in net proceeds from short-term borrowings and an increase in excess tax benefits from share-based compensation.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments, including long-term investments, of $25,519.0 at December 31, 2016. Since December 31, 2015, total cash, cash equivalents and investments, including long-term investments, increased by $2,394.3 primarily due to cash generated from operations, an increase in bank overdrafts changes, proceeds from the issuance of common stock under our employee stock plans and excess tax benefits from share-based compensation. These increases were partially offset by cash dividends paid to shareholders, purchases of property and equipment, payments on debt-related derivatives and net repayments of short-term and commercial paper borrowings.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory

accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2016, we held $1,445.8 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Debt

During the year ended December 31, 2015, we repurchased $920.0 of the aggregate principal balance of our outstanding senior convertible debentures due 2042, or the Debentures. In addition, $66.6 aggregate principal balance was surrendered for conversion by certain holders in accordance with the terms and provisions of the indenture governing the Debentures. We elected to settle the excess of the principal amount of the repurchases and conversions with cash for total payments of $2,055.7. We recognized a gain on the extinguishment of debt related to the Debentures of $12.7, based on the fair values of the debt on the repurchase and conversion settlement dates.

On September 10, 2015, we repaid, upon maturity, the $625.0 outstanding principal balance of our 1.25% senior unsecured notes due 2015. Additionally, during the year ended December 31, 2015, we repurchased $13.0 of outstanding principal balance of certain other senior unsecured notes, plus applicable premium, accrued and unpaid interest, for cash totaling $16.2. We recognized a loss on extinguishment of debt of $3.4 on the repurchase of these notes.

On May 12, 2015, we issued 25.0 Equity Units, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of $1,250.0. Each Equity Unit has a stated amount of $50 (whole dollars) and consists of a purchase contract obligating the holder to purchase a certain number of shares of our common stock on May 1, 2018, subject to earlier termination or settlement, for a price in cash of $50 (whole dollars); and a 5% undivided beneficial ownership interest in $1,000 (whole dollars) principal amount of our 1.900% remarketable subordinated notes, due 2028. We received $1,228.8 in cash proceeds from the issuance of the Equity Units, net of underwriting discounts and commissions and offering expenses payable by us, and recorded $1,250.0 in long-term debt.

On September 15, 2014, we redeemed the $500.0 outstanding principal balance of our 5.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling $512.3. We recognized a loss on extinguishment of debt of $2.3 on the redemption of these notes.

On September 11, 2014, we redeemed the $1,097.9 outstanding principal balance of our 5.250% senior unsecured notes due 2016, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling $1,178.2. We recognized a loss on extinguishment of debt of $67.6 on the redemption of these notes. Additionally, during the year ended December 31, 2014, we repurchased $52.0 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium for early redemption plus accrued and unpaid interest, for cash totaling $61.0. We recognized a loss on extinguishment of debt of $11.2 for the year ended December 31, 2014 on the repurchase of these notes.

On August 12, 2014, we issued $850.0 of 2.250% notes due 2019, $800.0 of 3.500% notes due 2024, $800.0 of 4.650% notes due 2044, and $250.0 of 4.850% notes due 2054 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 5.000% and 5.250% senior unsecured notes discussed above, and the remaining net proceeds were used for general corporate purposes. Interest on the notes is payable semi-annually in arrears on February 15 and August 15 of each year and commenced on February 15, 2015. The notes have a call feature that allows us to redeem the notes at any time at our option and a put feature that allows a note holder to redeem the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating. For additional information related to our borrowing activities, see Note 12, “Debt” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our audited consolidated balance sheets included in Part II, Item 8 of this Annual Report on Form 10-K. Our debt-to-capital ratio is calculated as the sum of short-term borrowings, plus current portion of long-term debt, plus long-term debt, less current

portion, divided by the sum of short-term borrowings, plus current portion of long-term debt, plus long-term debt, less current portion, plus total shareholders' equity. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 38.5% and 40.8% as of December 31, 2016 and 2015, respectively. We expect that our pro forma debt-to-capital ratio will approximate 49% following the closing of the acquisition of Cigna, and we are committed to deleveraging to the low 40% range approximately twenty-four months following the closing.

Our senior debt is rated "A" by Standard & Poor's, "BBB" by Fitch, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+ by AM Best Company, Inc. Following the announcement of the Merger Agreement, each of these rating agencies placed certain of our debt, financial strength and other credit ratings under review for a possible downgrade, however, we intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Future Sources and Uses of Liquidity

During the year ended December 31, 2015, we entered into a bridge facility commitment letter and a joinder agreement, and a term loan facility, to finance a portion of the pending acquisition of Cigna. In January 2017, we reduced the amount available under the bridge facility commitment letter from $22,500.0 to $19,500.0, and extended the termination date under the Merger Agreement, as well as the availability for commitments under the bridge facility and term loan facility, to April 30, 2017. The commitment of the lenders to provide the bridge facility and the term loan facility is subject to several conditions, including the completion of the acquisition of Cigna. For additional information, see the "Overview" section included in this "Management's Discussion and Analysis of Financial Condition and Results of Operations"; and Note 3, "Business Acquisitions and Divestiture - Pending Acquisition of Cigna Corporation" included in Part II, Item 8 of this Annual Report on Form 10-K.

We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

We have a senior revolving credit facility, or the Facility, with a group of lenders for general corporate purposes. The Facility provides credit up to $3,500.0 and expires on August 25, 2020. The interest rate on the Facility is based on either the LIBOR rate or a base rate plus a predetermined rate based on our public debt rating at the date of utilization. Our ability to borrow under the Facility is subject to compliance with certain covenants. There were no amounts outstanding under the senior revolving credit facilities at December 31, 2016 or 2015.

We have an authorized commercial paper program of up to $2,500.0, the proceeds of which may be used for general corporate purposes. At December 31, 2016 and 2015, we had $629.0 and $682.2, respectively, of borrowings outstanding under our commercial paper program. Commercial paper borrowings are classified as long-term debt as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year and we have the ability to redeem our commercial paper with borrowings under the senior revolving credit facility described above.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, collectively, the FHLBs, and as a member we have the ability to obtain short-term cash advances subject to certain minimum collateral requirements. At December 31, 2016 and 2015, $440.0 and $540.0, respectively, were outstanding under our short-term FHLBs borrowings.

As discussed in "Financial Condition" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we are currently estimating approximately $1,900.0 of dividends to be paid to the parent company during 2017. During 2016, we received $2,688.8 of dividends from our subsidiaries.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of the cash dividend activity for the year ended December 31, 2016 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
February 18, 2016	March 10, 2016	March 25, 2016	$ 0.6500	$ 170.7
April 26, 2016	June 10, 2016	June 24, 2016	0.6500	170.9
July 26, 2016	September 9, 2016	September 26, 2016	0.6500	171.1
November 1, 2016	December 5, 2016	December 21, 2016	0.6500	171.3

On February 22, 2017, our Board of Directors declared a quarterly cash dividend of $0.6500 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 24, 2017 to the shareholders of record as of March 10, 2017.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On October 2, 2014, the Board of Directors authorized a $5,000.0 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings. There were no common stock repurchases during the year ended December 31, 2016. Total authorization remaining at December 31, 2016 was $4,175.9 and we expect to utilize the remaining authorized amount over a multi-year period, subject to market and industry conditions.

Contractual Obligations and Commitments

Our estimated contractual obligations and commitments as of December 31, 2016 are as follows:

	Payments Due by Period			
Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
On-Balance Sheet:				
Debt[1]	$24,551.2	$2,571.1	$3,615.7	$2,320.1	$16,044.3
Other long-term liabilities[2]	1,260.8	419.6	453.5	302.1	85.6
Off-Balance Sheet:				
Purchase obligations[3]	2,059.0	975.6	984.0	99.4	—
Operating lease commitments	770.5	149.7	258.5	161.2	201.1
	798.0	324.8	316.8	137.3	19.1

Investment commitments[4]					
Total contractual obligations and commitments	$129,439.5	$4,440.8	$5,628.5	$3,020.1	$16,350.1

1 Includes estimated interest expense.

2 Primarily consists of reserves for future policy benefits, projected other postretirement benefits, deferred compensation, supplemental executive retirement plan liabilities and certain other miscellaneous long-term obligations. Estimated future payments for funded pension benefits have been excluded from this table as we had no funding requirements under ERISA at December 31, 2016 as a result of the value of the assets in the plans.

3 Includes estimated payments for future services under contractual arrangements from third-party service contracts.

4 Includes unfunded capital commitments for alternative investments.

The above table does not contain $150.0 of gross liabilities for