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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **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

☐ **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: 001-35149

UNIVERSAL AMERICAN CORP.

(Exact name of registrant as specified in its charter)

Delaware	**27-4683816**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

44 South Broadway, Suite 1200, White Plains, New York 10601

(Address of principal executive offices and zip code)

(914) 934-5200
(Registrant's telephone number, including area code)

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 $.01 per share	New York Stock Exchange, Inc.

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically 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 during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K 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 definitions of "large accelerated filer," "accelerated filer," and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	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 ☒

The aggregate market value of the registrant's voting common stock held by non-affiliates of the registrant on June 30, 2016, the last business day of the registrant's most recently completed second fiscal quarter, was approximately $331 million (based on the closing sales price of the registrant's common stock on that date). As of February 24, 2017, 59,428,232 shares of the registrant's voting common stock were issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information contained in Part III, Items 10-14 of this Annual Report on Form 10-K will be included in the Company's definitive Proxy Statement for the 2017 Annual Meeting of Stockholders to be filed with the U.S. Securities and Exchange Commission.

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As used in this Annual Report on Form 10-K, except as otherwise indicated, references to the "Company," "Universal American," "we," "our," and "us" are to Universal American Corp., a Delaware corporation, and its subsidiaries.

DISCLOSURE REGARDING FORWARD LOOKING STATEMENTS

This report, including, without limitation, the information set forth or incorporated by reference in Item 1 "Business," Item 1A "Risk Factors" and Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations," and other risks and uncertainties set forth in this report and oral statements made from time to time by our executive officers contains "forward-looking" statements within the meaning of Section 21E of the Securities Exchange Act of 1934, as amended, and the Private Securities Litigation Reform Act of 1995, known as the PSLRA. Statements in this report that are not historical facts are hereby identified as forward-looking statements and are intended to be covered by the safe harbor provisions of the PSLRA. They can be identified by the use of the words "believe," "expect," "predict," "project," "potential," "estimate," "anticipate," "should," "intend," "may," "will" and similar expressions or variations of such words, or by discussion of future financial results and events, strategy or risks and uncertainties, trends and conditions in the Company's business and competitive strengths, all of which involve risks and uncertainties.

Where, in any forward-looking statement, we or our management expresses an expectation or belief as to future results or actions, there can be no assurance that the statement of expectation or belief will result or be achieved or accomplished. Our actual results may differ materially from our expectations, plans or projections. We warn you that forward-looking statements are only predictions and estimates, which are inherently subject to risks, trends and uncertainties, many of which are beyond our ability to control or predict with accuracy and some of which we might not even anticipate. We give no assurance that we will achieve our expectations and we do not assume responsibility for the accuracy and completeness of the forward-looking statements. Future events and actual results, financial and otherwise, may differ materially from the results discussed in the forward-looking statements as a result of many factors, including the risk factors described or incorporated by reference in Part I, Item 1A of this report. We caution readers not to place undue reliance on these forward-looking statements that speak only as of the date made.

We undertake no obligation, other than as may be required under the federal securities laws, to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Although we believe that the expectations reflected in these forward-looking statements are reasonable at the time made, any or all of the forward-looking statements contained in this report and in any other public statements that are made may prove to be incorrect. This may occur as a result of inaccurate assumptions as a consequence of known or unknown risks and uncertainties. All of the forward-looking statements are qualified in their entirety by reference to the factors discussed or incorporated by reference under the caption "Risk Factors" under Part I, Item 1A of this report. We caution that these risk factors may not be exhaustive. We operate in a continually changing business environment that is highly complicated, regulated and competitive and new risk factors emerge from time to time. We cannot predict these new risk factors, nor can we assess the impact, if any, of the new risk factors on our business or the extent to which any factor or combination of factors may cause actual results to differ materially from those expressed or implied by any forward-looking statement. In light of these risks, uncertainties and assumptions, the forward-looking statements discussed in this report might not occur. You should carefully read this report and the documents that we incorporate by reference in this report in its entirety. It contains information that you should consider in making any investment decision in any of our securities.

PART I

BUSINESS

Universal American, through our family of healthcare companies, provides health benefits to people covered by Medicare. Our core strength is our ability to partner with providers, especially primary care physicians, to improve health outcomes while reducing cost in the Medicare population. We currently are focused on two main businesses:

- **Medicare Advantage:** We currently serve the growing Medicare population by providing Medicare Advantage products to approximately 119,500 members. Approximately 31% of the Medicare population in the United States is currently enrolled in Medicare Advantage plans; a type of Medicare health plan offered by private companies that contract with the federal government to provide enrollees with health insurance. Our current focus is to grow our Medicare Advantage business in Texas (especially Houston/Beaumont), upstate New York and Maine, regions in which we have meaningful market positions.

- **Medicare Accountable Care Organizations:** We believe there is a significant opportunity to address the high cost and lack of coordination of health care for the majority of the Medicare fee-for-service population and have joined with provider groups to operate Accountable Care Organizations, or ACOs, that participate in the Medicare Shared Saving Program, known as the MSSP. We currently operate sixteen MSSP ACOs and two Next Generation ACOs, including approximately 5,200 participating providers with approximately 221,800 assigned Medicare fee-for-service beneficiaries.

Healthy Collaboration® Strategy

We have developed a successful primary care physician alignment strategy that we have branded as The Healthy Collaboration®. We work in collaboration with healthcare providers, especially primary care physicians, to help them assume and manage risk, in order to achieve measurably better quality and lower cost. Primary care is among the least expensive parts of the overall care continuum. We believe that if given the right tools and incentives, primary care physicians can have significant leverage in improving the cost and quality of health care. Below are the key elements of the strategy:

- We align incentives through gain sharing arrangements so that providers are incented to assist members to achieve healthy outcomes;

- We provide actionable data and analytics to providers and employ enabling technology to ensure that the right care is delivered at the right time in the right setting; and

- We engage the people we serve to help them make informed choices about their healthcare.

Pending Sale to WellCare

On November 17, 2016, we entered into a definitive agreement with WellCare Health Plans, Inc. ("WellCare") under which WellCare will acquire Universal American in an all cash transaction valued at $10.00 per share of common stock. We refer to this transaction throughout this Form 10-K as the "Sale Transaction." On December 30, 2016, the request for early termination of the waiting period under the Hart-Scott-Rodino Antitrust Improvements Act (HSR Act) was approved. In addition, on February 16, 2017, our stockholders approved the Sale Transaction. WellCare and the Company are pursuing the remaining regulatory approvals from regulatory agencies in Texas and New York. The Sale Transaction is expected to close in the second quarter of 2017, subject to the receipt of regulatory approvals and other customary closing conditions.

Our Operating Segments

We manage and report our business as follows:

- The Medicare Advantage segment contains the operations of our initiatives in managed care for seniors, including Health Maintenance Organization, or HMO plans, Preferred Provider Organization, or PPO plans and Private Fee-for-Service or PFFS plans.

- Management Services Organization, or MSO, segment supports our physician partnerships in the development of value-based healthcare models, such as ACOs, with a variety of capabilities and resources including technology, analytics, clinical care coordination, regulatory compliance and program administration.

- Corporate & Other segment reflects the activities of our holding company.

- Discontinued Operations includes the activities of non-core businesses that we have sold over the last two years; the Traditional Insurance business and the Total Care Medicaid Plan sold in 2016 and APS Healthcare sold in 2015. These dispositions represent our strategic shift to focus on our core businesses.

Medicare Advantage

We believe that attractive growth opportunities exist in providing health insurance to the growing senior market. At present, approximately 57 million Americans are eligible for Medicare, the Federal program that offers basic hospital and medical insurance to people over 65 years old and some disabled people under the age of 65. According to the Pew Research Center, more than 3.5 million Americans turn 65 in the United States each year, and this number is expected to grow as the so-called baby boomers continue to turn 65 and continue for nearly 20 years. In addition, many large employers that traditionally provided medical and prescription drug coverage to their retirees have begun to curtail these benefits. Medicare Advantage continues to grow its share of the overall Medicare market and we believe is likely to continue to gain positive acceptance with consumers.

Over the past several years, we made a strategic decision to offer Medicare Advantage plans only in markets where we believe we can positively impact the cost and quality of healthcare through collaboration with providers. Accordingly, we now offer plans in only three states (Texas, New York and Maine). In the Houston/Beaumont region, we currently maintain the leading market position with strong brand awareness and committed and aligned physician groups with whom we share risk. In upstate New York, we are in the process of converting this historically fee-for-service market into a more value-based system by introducing pay for performance to the primary care physicians in the region.

The chart below details our current Medicare Advantage membership:

	January 31, 2017	December 31, 2016
	(in thousands)	
Houston/Beaumont	69.2	65.8
Dallas	2.4	2.9
SETX dSNP	0.5	0.4
Texas	72.1	69.1
Upstate New York/Maine	47.4	45.4
Medicare Advantage	119.5	114.5

For 2017, the Company earned a 4.5 Star rating for its flagship TexanPlus® plan in Houston/Beaumont, which accounts for 57% of our December 31, 2016 membership, and maintained a 4 Star

rating for our Today's Options PPO plan in New York and Maine. Collectively, over 70% of our members are in Plans with a Star rating of 4.0 or greater. Plans that achieve a 4 Star rating or better are entitled to additional bonus payments and higher rebate percentages from CMS which enables the plans to enhance their product offering to members and prospective members through reduced premiums, reduced member cost sharing amounts, and/or additional benefits. A summary of these ratings is presented below:

Contract	Plan Name	Location	January 31, 2017 Members (000's)	2017 Star Rating
H4506	Texan Plus HMO	Southeast Texas—Houston/Beaumont	69.2	4.5
H2775	Today's Options PPO	Northeast—New York & Maine	19.8	4.0
H0174	Texan Plus D-SNP	Southeast Texas	0.5	4.0
H2816	Today's Options Network PFFS	Northeast—New York & Maine	27.6	3.5
H5656	Texan Plus HMO	North Texas—Dallas	2.4	3.0
			119.5	

Medicare Advantage—Texas: Universal American's largest Medicare Advantage market is Texas, primarily the Houston/Beaumont region and North Texas. We market our products using the TexanPlus® brand. The products provided in our Texas markets are HMO plans, including a special needs plan for dual eligibles (dSNP), which was introduced in 2016 and currently has nominal membership. Enrollment in this market is generally supported by employed career agents.

- Our HMO plans are offered under contracts with CMS and provide all basic Medicare covered benefits with reduced member cost-sharing as well as additional supplemental benefits, including a defined prescription drug benefit. We built this coordinated care product around contracted networks of providers who, in cooperation with the health plan, coordinate an active care management program. In addition to a monthly payment per member from CMS, the plan may collect a monthly premium from its members enrolled in specified products. For 2017, these HMO plans are offered with a $0 member premium, except for the dSNP, which offers a subsidized premium.

- In connection with the HMOs, we operate separate Medicare Advantage Management Service Organizations that manage that business and affiliated Independent Physician Associations or IPAs through gain sharing arrangements. We participate in the net results derived from these affiliated IPAs.

Medicare Advantage—Northeast: Universal American's second largest market is upstate New York, primarily the ten counties that are considered part of the Syracuse market. Universal American markets its Medicare Advantage products using the Todays Options® brand. Enrollment in this market is generally supported by independent agents.

The products provided in our Northeast market include PPO and Network PFFS.

- Our PPO plans are provided under the brand Today's Options® PPO. They are offered under contracts with CMS and provide all basic Medicare covered benefits with reduced member cost-sharing as well as additional supplemental benefits, including a defined prescription drug benefit. This coordinated care product is built around contracted networks of providers who, in cooperation with the health plan, coordinate an active care management program. In addition to a monthly payment per member from CMS, the plan may collect a monthly premium from its members enrolled in specified products.

- Our Network PFFS plans, which are provided under the brand Today's Options® are offered under contracts with CMS and provide enhanced health care benefits compared to traditional Medicare, subject to cost sharing and other limitations. Even though these plans allow the members more flexibility in the delivery of their health care services than other Medicare Advantage plans, we actively coordinate care for these members in a similar manner to our PPO and HMO plans. Some of these products include a defined prescription drug benefit. In addition to a fixed monthly payment per member from CMS, individuals in these plans may be required to pay a monthly premium in selected counties or for selected enhanced products.

Accountable Care Organizations

The Patient Protection and Affordable Care Act and The Healthcare and Education Reconciliation Act of 2010, which we collectively refer to as the ACA, established Medicare Shared Savings ACOs as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service, or FFS, program, which covers the majority of the Medicare-eligible population. The MSSP covers nearly eight million FFS beneficiaries comprising approximately 430 ACOs. CMS established the MSSP to facilitate coordination and cooperation among providers to improve the quality of care for FFS beneficiaries and reduce unnecessary costs. The MSSP is designed to improve beneficiary outcomes and increase value of care by:

- promoting accountability for the care of Medicare FFS beneficiaries;
- fostering better coordination of care for items and services provided under Medicare FFS; and
- encouraging investment in infrastructure and redesigned care processes.

The MSSP will reward ACOs that lower their health care costs while surpassing a minimum savings rate and meeting quality of care performance standards. Cost savings below the benchmark provided by CMS will be shared at least 50% with the ACOs. The minimum savings rate set by CMS varies depending on the number of beneficiaries assigned to the ACO, starting at 3.9% for ACOs with assigned beneficiaries totaling 5,000 and grading to 2.0% for ACOs with assigned beneficiaries totaling 60,000 or more.

In June 2015, the MSSP rules were revised in several important ways that we believe demonstrates an ongoing commitment by CMS to maintain participation in the MSSP. For example, Medicare ACOs now have more options under the MSSP, such as:

- **MSSP Track 1:** One-sided risk (upside only); up to 50% shared savings; retrospective attribution
- **MSSP Track 2:** Two-sided risk; up to 60% shared savings; retrospective attribution
- **MSSP Track 3:** Two-sided risk; up to 75% shared savings; prospective attribution

Additionally, the CMS Center for Medicare and Medicaid Innovation, or CMMI, launched the Next Generation ACO Model, a new value-based payment model that encourages providers to assume greater risk and reward in coordinating the healthcare of Medicare fee-for-service beneficiaries. The Next Generation ACO Model provides ACOs with additional tools not found in the MSSP but used in the Medicare Advantage program to improve quality and lower cost, including preferred networks, negotiated discounts and beneficiary incentives. The Next Generation ACO Model offers two risk arrangements with prospectively assigned beneficiaries under which a Next Generation ACO can share up to 80% or 100% of savings (losses) generated in each performance year depending on the financial arrangement selected by the ACO.

Universal American currently sponsors sixteen MSSP ACOs in ten States and two Next Generation ACOs which include approximately 5,200 participating providers and approximately 221,800 Medicare FFS beneficiaries covering more than $2.4 billion of medical spend. Certain of our ACOs overlap a

portion of our Medicare Advantage footprint (Houston, Dallas and New York) which capitalizes on our existing relationship with providers. The other ACOs have no overlap with existing operations, offering an opportunity for expansion into other products and services.

In 2017, three of our MSSP ACOs elected Track 2 with the balance of MSSP ACOs remaining on Track 1. In addition, we formed a new ACO comprised of many of our providers who participated in our Maryland and Virginia ACOs which was selected by CMS to participate in the Next Generation ACO model effective January 1, 2017. Our other Next Generation ACO operates in Houston, Texas.

We provide our ACOs with care coordination, analytics and reporting, technology and other administrative capabilities to enable participating providers to deliver better care and lower healthcare costs for their Medicare FFS beneficiaries. We employ local market staff (operations and clinical) to drive physician and their staff engagement and care coordination improvements. Over the past few years, we have reduced the number of our active ACOs based on a variety of factors, including the level of engagement by the physicians in the ACO and the likelihood of the ACO achieving shared savings. We may make further reductions in the future. For additional information regarding the MSSP, see *Regulation—Accountable Care Organizations*.

Discontinued Operations

Over the last two years, in connection with our strategic shift to focus on our core businesses, we completed the sale of our non-core businesses. On August 3, 2016 we sold our Traditional Insurance business to Nassau Reinsurance Group Holdings, L.P. On August 1, 2016, we sold our subsidiary, Today's Options of New York, Inc., which operates the Total Care Medicaid plan, to Molina Healthcare, Inc. On May 1, 2015, we sold our APS Healthcare domestic subsidiaries and we sold our APS Healthcare Puerto Rico subsidiaries on February 4, 2015. These businesses are all reported as discontinued operations.

Healthcare Reform

The ACA was signed into law in March 2010 and legislated broad based changes to the U.S. health care system which continue to have a material impact on our business. There is considerable discussion within the new Presidential administration and Congress about repealing and replacing the ACA. At this time, it is uncertain whether, when, and what changes will be made to the ACA, and what impact such changes could have on our business. However, any changes to the ACA, including through any repeal and replacement to the ACA, could have a material adverse effect on our business, financial position and results of operations.

The provisions of these new laws include the following key points, which are discussed further below:

- reduced Medicare Advantage reimbursement rates, beginning in 2012;
- implementation of a quality bonus for Star ratings, beginning in 2012;
- accountable care organizations, beginning in 2012;
- stipulated minimum medical loss ratios, beginning in 2014;
- non-deductible health insurance industry fee, beginning in 2014;
- coding intensity adjustments, with mandatory minimums, beginning in 2014; and
- limitation on the federal tax deductibility of compensation earned by individuals for certain types of companies, beginning in 2013.

For further discussion, please see "Healthcare Reform" under Item 7—Management's Discussion and Analysis of Financial Condition and Results of Operations in this report.

Competition

The health insurance industry is highly competitive. In the Medicare Advantage business, we compete with numerous other health insurance companies and managed care organizations on a national, regional and local market basis, including United Healthcare, Humana, Cigna, Aetna, various plans affiliated with Blue Cross Blue Shield and WellCare, as well as other health maintenance organizations, provider-sponsored organizations, preferred provider organizations, and other health care-related companies. Most of our competitors have larger memberships and/or greater financial resources. Consolidation within the industries in which we operate, as well as the acquisition of our competitors by larger companies may lead to increased competition.

In our ACO business, we compete with hospitals, health systems, sophisticated provider groups, other payors, and management service organizations, among other groups. Our ability to sell our products and to retain customers may be influenced by such factors as those described in the section entitled "*Risk Factors*" in this report.

Marketing and Distribution

We distribute our Medicare Advantage products through multiple channels including employed career agents and independent agents as well as telephonic and internet enrollment. Our MSSP ACOs do not have a sales component as beneficiaries are attributed to an ACO by CMS based on the provider from which they receive a plurality of services.

Geographical Distribution of Business

The following table shows the geographical distribution of net premiums for our Medicare Advantage business (in millions), as reported in accordance with generally accepted accounting principles, known as GAAP, for the years ended December 31, 2016 and 2015:

	2016		2015	
State/Region	Net Premiums	% of Premium	Net Premiums	% of Premium
Texas	$ 869.8	63.6%	$ 844.6	67.8%
New York	456.2	33.4%	372.7	29.9%
Maine	37.8	2.8%	25.8	2.1%
Subtotal	1,363.8	99.8%	1,243.1	99.8%
All other	2.9	0.2%	2.6	0.2%
Total	$ 1,366.7	100.0%	$ 1,245.7	100.0%

Provider Arrangements. Our network providers deliver health care services to members enrolled in our Medicare Advantage coordinated care plans to which we provide services through a network of contracted providers, including physicians, behavioral health providers and other clinical providers, hospitals, a variety of outpatient facilities and the full range of ancillary provider services. The major ancillary services and facilities include:

- ambulance services;
- medical equipment services;
- home health agencies;

- home infusion providers;
- mental health and substance abuse providers;
- rehabilitation facilities;
- skilled nursing facilities;
- optical services; and
- pharmacies.

We use a wide range of systems and processes to organize and deliver needed health care services to our members. The key steps in this process are:

- the careful selection of primary care physicians to provide overall care management and care coordination of members;
- development of a comprehensive panel of specialists usually selected by the primary care physicians;
- contracting for the balance of needed services based on the preference and experience of the local physicians; and
- arranging for the full range of medical management systems required to support the primary care and specialist physicians.

We employ health evaluation and assessment tools, quality improvement, care management and credentialing programs to ensure that we meet target goals relating to the provision of quality patient care by our providers. The major medical management systems are:

- an inpatient hospitalist program at contracted hospitals;
- selected authorization of target services;
- referral management;
- case management;
- transition of care management;
- in-home interventions;
- focused chronic illness management;
- transplant coordinator services; and
- outpatient prescription drug management.

Investments

Our investment policy is to attempt to balance our portfolio duration to achieve investment returns consistent with the preservation of capital and maintenance of liquidity adequate to meet claim payment obligations. We invest in assets permitted under the insurance laws of the various states in which we operate. These laws generally prescribe the nature, quality of and limitations on various types of investments that we may make. In addition, we establish our own internal

policies, guidelines and constraints to provide additional granularity and conservatism to our investment process. Such guidelines are reviewed at least annually by our Chief Financial Officer and approved by the Investment Committee of the Board of Directors.

Reserves

We establish, and carry as liabilities in our financial statements prepared in accordance with GAAP and statutory accounting practices, actuarially determined reserves in accordance with applicable insurance regulations. For further discussion, see Critical Accounting Policies in our Management's Discussion and Analysis of Financial Condition and Results of Operations elsewhere in this Annual Report on Form 10-K.

For Medicare Advantage, claims reserves are estimated using standard actuarial development methodologies. Under such methods, we take into consideration the historical lag between incurred date of claim and payment date of claim, membership changes, expected medical cost trend, changes in pending claims, amount of claims receipts, claims seasonality, changes in average risk profile, changes in laws, rules, regulations (including CMS coverage guidelines, where applicable) and benefit plan changes.

Reinsurance of Medicare Advantage

We maintain excess of loss reinsurance on our Medicare Advantage products, which limits our per member risk. Our retention in 2016 was $300,000 of benefits and 10% in excess of the $300,000, except for one company, Select Care of Texas, for which our retention in 2016 was $325,000 of benefits and 10% in excess of the $325,000.

Reinsurance of Traditional Insurance (Discontinued Operations)

On August 3, 2016, as discussed in Note 21—Discontinued Operations, we completed the sale of our Traditional Insurance business. This was accomplished by selling two of our life insurance subsidiaries, however we retained ownership of a third life insurance subsidiary, American Progressive Life & Health Insurance of New York, or Progressive, in which we also write our New York and Maine Medicare Advantage business. The sale of the Traditional Insurance business underwritten by Progressive was accomplished through a 100% quota-share reinsurance treaty that, when considered in combination with other reinsurance transactions previously entered into, results in the reinsurance of all of the Traditional Insurance policies that were underwritten on Progressive.

Underwriting Procedures

For our Medicare Advantage products, pursuant to applicable regulations, we are not permitted to underwrite new enrollees. However, premiums received for these members are risk adjusted based on CMS adjustment policies reflecting the health status for each member.

Regulation

General

Our insurance and HMO companies along with certain other subsidiaries are subject to the state and local laws, regulations and supervision of the jurisdictions in which they are domiciled and licensed, as well as to federal laws and supervision. Those laws and regulations provide safeguards for policyholders, members and beneficiaries, and do not exist to protect the interest of shareholders. Government agencies that oversee insurance and health care products and services generally have broad authority to issue regulations to interpret and enforce laws and rules. Changes in applicable laws and regulations are continually being considered, and the interpretation, enforcement, and application of existing laws and rules also change periodically, which could make it increasingly difficult to control medical costs, among other things. Therefore, future regulatory revisions could materially affect our operations and financial results.

We are subject to various governmental reviews, audits and investigations to verify our compliance with our contracts and applicable laws and regulations. For example, state departments of insurance audit our health plans and insurance companies for financial and contractual compliance. State departments of health audit our health plans for compliance with health services. The Centers for Medicare & Medicaid Services, also known as CMS, the Office of the Inspector General of Health and Human Services, the Department of Justice, the Department of Labor, the Government Accountability Office, the foregoing state equivalent agencies, state attorneys general, state departments of insurance and departments of health and Congressional committees may also conduct audits and investigations of us. In addition, we are a public company and subject to the oversight and regulation of the Securities and Exchange Commission, New York Stock Exchange and other agencies.

Medicare

Medicare is a federal program that provides eligible persons age 65 and over and certain eligible persons with disabilities under age 65 with a variety of hospital, prescription drug, and medical insurance benefits. Medicare members have the option to enroll in a Medicare Advantage health plan. Under Medicare Advantage, insurance companies and managed care organizations contract with CMS to provide benefits at least equivalent to the traditional fee-for-service Medicare program in exchange for a fixed monthly payment per member that varies based on the county in which a member resides as well as a member's demographics and health status.

The Medicare Part D drug benefit offers Medicare members the option to obtain covered outpatient prescription drug benefits either as a stand-alone plan or offered in conjunction with a Medicare Advantage health plan. Certain of our Medicare Advantage plans offer a Medicare Part D drug benefit.

The ACA made several changes to Medicare Advantage. Beginning in 2012, the Medicare Advantage "benchmark" rates began the transition to target Medicare fee-for-service cost benchmarks of 95%, 100%, 107.5% or 115% of the calculated Medicare fee-for-service costs. The transition period is 2, 4 or 6 years depending upon the applicable county and 2017 will be the final transition year. The counties are divided into quartiles based on each county's fee-for-service Medicare costs. We estimate that approximately 61%, 32% and 6%, respectively, of our January 1, 2017 membership resides in counties where the Medicare Advantage benchmark rate will equal 95%, 115%, and 107.5%, respectively, of the calculated Medicare fee-for-service costs.

Implementation of quality bonus for Star ratings—Beginning in 2012, Medicare Advantage plans with an overall "Star rating" of three or more stars (out of five) based on historical performance were eligible for a "quality bonus" in their basic premium rates. Plans receiving Star bonus payments are required to use the additional dollars to provide "extra benefits" for the plans' enrollees, to the extent necessary to maintain compliance with minimum loss ratio requirements, resulting in a competitive advantage for those plans rather than a direct financial impact. In addition, beginning in 2012, Medicare Advantage Star ratings affect the rebate percentage available for plans to provide additional member benefits (plans with quality ratings of 3.5 stars or above will have their rebate percentage increased from a base rate of 50% to 65% or 70%). In all cases, this rebate percentage is lower than the pre-ACA rebate percentage of 75%. Beginning in 2015, in order to qualify for bonus payments, plans must have a 4 Star rating or higher. For 2017, the Company earned a 4.5 Star rating for its flagship TexanPlus® plan in Houston/Beaumont, which accounts for 57% of our December 31, 2016 membership, and maintained a 4 Star rating for our Today's Options PPO plan in New York and Maine. Collectively, over 70% of our members are in Plans with a Star rating of 4.0 or greater.

Notwithstanding continued efforts to improve or maintain our Star ratings and other quality measures, there can be no assurances that we will be successful. Accordingly, our plans may not be eligible for full level quality bonuses or increased rebates, which could adversely affect the benefits such plans can offer, reduce membership, and reduce profit margins.

In addition, CMS has indicated that plans with a Star rating of less than 3.0 for three consecutive years may be subject to termination. While we do not currently have any plans with a rating below 3.0, our inability to maintain Star ratings of 3.0 or better for a sustained period of time could ultimately result in plan termination by CMS which could have a material adverse impact on our business, cash flows and results of operations. Also, the CMS Star ratings/quality scores may be used by CMS to pay bonuses to Medicare Advantage plans that enable those plans to offer improved benefits and/or better pricing. Furthermore, lower quality scores compared to our competitors may result in us losing potential new business in new markets or dissuading potential members from choosing our plan in markets in which we compete. Lower quality scores compared to our competitors could have a material adverse effect on our rate of growth.

Stipulated minimum MLRs—Beginning in 2014, the ACA stipulates a minimum medical loss ratio, or MLR, of 85% for Medicare Advantage plans. This MLR, which is calculated at a plan level, takes into account benefit costs, quality initiative expenses, the ACA fee and taxes. Financial and other penalties may result from failing to achieve the minimum MLR ratio. For the years ended December 31, 2016, 2015 and 2014 our Medicare Advantage plans exceeded the minimum MLR, as defined by CMS. Complying with such minimum ratio by increasing our medical expenditures or refunding any shortfalls to the federal government could have a material adverse effect on our operating margins, results of operations, and our statutory capital.

Non-deductible health insurance industry fee ("ACA Fee")—Beginning in 2014, the new healthcare reform legislation imposed an annual aggregate health insurance industry fee of $8.0 billion, increasing to $11.3 billion in 2015 and 2016 (with increasing annual amounts thereafter) on health insurance premiums, including Medicare Advantage premiums, that is not deductible for income tax purposes. In 2017, the ACA Fee has been suspended for one year. Our share of the ACA Fee is based on our pro rata percentage of premiums written during the preceding calendar year compared to the industry as a whole, calculated annually. The ACA Fee, first expensed and paid in 2014, adversely affects the profitability of our Medicare Advantage business and could have a material adverse effect on our results of operations. For our continuing operations, we paid ACA Fees of $21.7 million, $25.5 million and $22.9 million in the years ended December 31, 2016, 2015 and 2014, respectively, based on prior year net written premiums. We do not expect to pay any ACA Fees in 2017, due to the one year suspension of the ACA Fee. Pursuant to GAAP, the liability for the ACA Fee will be estimated and recorded in full once the entity provides qualifying health insurance in the corresponding period with a corresponding deferred cost that is to be amortized to expense on a straight-line basis over the applicable calendar year. For statutory reporting purposes, the ACA Fee will be expensed on January 1 in the year of payment, rather than amortized to expense over the year. The ACA Fee is included in other operating costs; however, will be factored in when calculating the stipulated minimum MLR. Our effective income tax rate increased in 2014, and will remain at a higher level in future years in which the ACA Fee is assessed.

Accountable Care Organizations

The ACA established Medicare ACOs, as a tool to improve quality and lower costs through increased care coordination in the FFS program. CMS established the MSSP to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. To date, we have partnered with numerous groups of healthcare providers and currently participate in sixteen MSSP ACOs and two Next Generation ACOs. ACOs are entities that contract with CMS to serve the FFS population with the goal of better care for individuals, improved health for populations and lower costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. We provide a variety of services to the ACOs, including care coordination, analytics and reporting, technology and other administrative services to enable these physicians and their associated healthcare providers to deliver better quality care, improved health and lower healthcare costs for their Medicare FFS patients.

Under the MSSP, CMS will not make any payments to ACOs for a measurement year until the second half of the following year, which negatively impacts our cash flows. In order to receive revenues from CMS under the MSSP, the ACO must meet certain minimum savings rates (i.e. save the federal government money) and meet certain quality measures. More specifically, an ACO's medical expenses for its assigned beneficiaries during a relevant measurement year must be below the benchmark established by CMS for such ACO. On the quality side, for 2017, the MSSP requires ACOs to meet various quality measures, which CMS may vary from time to time. Notwithstanding our efforts, our ACOs may be unable to meet the required savings rates or may not satisfy the quality measures, which may result in our receiving no revenues and losing our substantial investment. In addition, as the MSSP is a new program, it presents challenges and risks associated with the timeliness and accuracy of data and interpretation of complex rules, which may impact the timing and amount of revenue we can recognize and could have a material adverse effect on our ability to recoup any of our investment in this new business. Further, there can be no assurance that we will maintain positive relations with our ACO partners which may result in certain of the ACOs terminating our relationship, which will result in a potential loss of our investment.

On June 4, 2015, CMS released a final rule updating provisions related to the MSSP in the second contract period for years 2016-2019. This final rule made several changes, including allowing ACOs to participate in Track 1 for a second agreement period with the same sharing rate (up to 50%), establishing a new Track 3 with two-sided risk with additional flexibilities, providing new beneficiary-level claims data that will improve overall ACO information, and easing certain administrative requirements.

Additionally, the CMS Center for Medicare and Medicaid Innovation, or CMMI, launched the Next Generation ACO Model, a new value-based payment model that encourages providers to assume greater risk and offers enhanced rewards for coordinating the healthcare of Medicare fee-for-service beneficiaries. The Next Generation ACO model provides ACOs with additional tools not found in the MSSP but used in the Medicare Advantage program to improve quality and lower cost, including preferred networks, negotiated discounts and beneficiary incentives. The Next Generation ACO model offers two risk arrangements with prospectively assigned beneficiaries under which a Next Generation ACO can share up to 80% or 100% of savings (losses) generated in each performance year depending on the financial arrangement selected by the ACO.

In addition, CMS, the US Office of Inspector General, the Internal Revenue Service, the Federal Trade Commission, the US Department of Justice, and various states have adopted or are considering adopting new legislation, rules, regulations and guidance relating to formation and operation of ACOs. Such laws may, among other things, require ACOs to become subject to financial regulation such as maintaining deposits of assets with the states in which they operate, the filing of periodic reports with the insurance department and/or department of health, or holding certain licenses or certifications in the jurisdictions in which the ACOs operate. Failure to comply with legal or regulatory restrictions may result in CMS terminating an ACOs agreement with CMS and/or subjecting an ACO to loss of the right to engage in some or all business in a state, payment of fines or penalties, or may implicate federal and state fraud and abuse laws relating to anti-trust, physician fee-sharing arrangements, anti-kickback prohibitions or prohibited referrals, any of which may adversely affect our operations and/or profitability.

Fraud and abuse laws

Enforcement of health care fraud and abuse laws has become a top priority for the nation's law enforcement entities. The funding of these law enforcement efforts has increased dramatically in the past few years and is expected to continue. The focus of these efforts has been directed at participants in federal government health care programs such as Medicare and Medicaid.

Privacy laws

The use and disclosure of personal health information, personally identifiable information, and/or individually identifiable data by our business is regulated at federal and state levels. These laws and rules are subject to administrative interpretation. Various state laws address the use and maintenance of such data. Many state laws are derived from the privacy provisions in the Federal Gramm-Leach-Bliley Act, the Genetic Information Nondiscrimination Act, known as GINA, the Health Information Technology for Economic and Clinical Health Act of 2009, known as HITECH, and the Health Insurance Portability and Accountability Act of 1996, known as HIPAA.

Among other things, HIPAA mandates the following:

- guaranteed availability and renewability of health insurance for specified employees and individuals;
- limits on termination options and on the use of preexisting condition exclusions;
- prohibitions against discriminating on the basis of health status; and
- requirements which make it easier to continue coverage in cases where an employee is terminated or changes employers.

HIPAA also calls for the adoption of standards for the exchange of electronic health information and privacy requirements that govern the handling, use and disclosure of protected customer health information. Compliance with HIPAA and other privacy laws is far-reaching and complex and proper interpretation and practice under the law continue to evolve. Consequently, our efforts to measure, monitor and adjust our business practices to comply with these laws are ongoing. In 2013, the United States Department of Health and Human Services issued the omnibus final rule on HIPAA privacy, security, breach notification requirements and enforcement requirements under the HITECH Act, and a final regulation for required changes to the HIPAA Privacy Rule for the Genetic Information Nondiscrimination Act, or GINA. Our failure to comply with the omnibus final rule or the failure of our business associates to comply with HIPAA, the HITECH ACT, GINA, or other privacy regulations could cause us to incur civil or criminal penalties, including significant damage to our reputation.

State and local regulation

Each of our insurance company and HMO subsidiaries is also subject to the regulations of and supervision by the insurance department and/ or departments of health of each of the jurisdictions in which they are admitted and authorized to transact business. These regulations cover, among other things:

- the declaration and payment of dividends by our insurance company and HMO subsidiaries;
- the granting and revocation of licenses to transact business;
- the licensing of agents;
- the regulation and monitoring of market conduct and claims practices;
- the establishment of reserve requirements;
- investment restrictions;
- the regulation of maximum allowable commission rates;
- the mandating of some insurance benefits;
- minimum capital and surplus levels; and

- the form and accounting practices used to prepare statutory financial statements.

A failure to comply with legal or regulatory restrictions may subject the insurance company subsidiary or HMO subsidiary to a loss of a right to engage in some or all business in a state or states or an obligation to pay fines, penalties, or make restitution, which may adversely affect our profitability.

American Progressive Life & Health Insurance Company of New York is a New York domiciled insurance company. SelectCare of Texas, Inc., SelectCare Health Plans, Inc. and Today's Options of Texas, Inc. are each licensed as HMOs in Texas. Collectively, our insurance company and HMO subsidiaries are licensed to sell health insurance, HMO products, life insurance and annuities in 29 states and the District of Columbia.

Every insurance company and HMO that is a member of an "insurance holding company system" generally is required to register with the insurance regulatory authority in its domicile state and file periodic reports concerning its relationships with its insurance holding company and with its affiliates. Material transactions between registered insurance companies or HMOs and members of the holding company system are required to be "fair and reasonable" and in some cases are subject to administrative approval. The books, accounts and records of each party are required to be maintained so as to clearly and accurately disclose the precise nature and details of any intercompany transactions.

Each of our insurance company and HMO subsidiaries is required to file detailed reports with the insurance department of each jurisdiction in which it is licensed to conduct business and its books and records are subject to examination by each licensing insurance department. In accordance with the insurance codes of their domiciliary states and the rules and practices of the NAIC, our insurance company and HMO subsidiaries are examined periodically by examiners of each company's domiciliary state with elective participation by representatives of the other states in which they are licensed to do business.

Many states require deposits of assets by insurance companies and HMOs for the protection either of policyholders in those states or for all policyholders. These deposited assets remain part of the total assets of the company. For companies included in continuing operations as of both December 31, 2016 and 2015, we had securities with market values totaling $3.9 million, on deposit with various state treasurers or custodians.

Certain of our subsidiaries are licensed in various states as a third party administrator, utilization review agent, or other similar entities. Those subsidiaries provide administrative and management services to our insurance and HMO companies. Those entities operate in states that regulate intercompany agreement, including the amounts that can be charged between affiliates for services, fiduciary bond amounts, utilization review processes, and claims payment processes.

Dividend Restrictions

Many of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to other affiliated entities including our parent company, Universal American Corp., and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid by these subsidiaries, without prior approval by state regulatory authorities, is limited based on the entity's level of statutory income and statutory capital and surplus.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly from state to state. As of December 31, 2016, our state regulated subsidiaries had aggregate statutory capital and surplus of approximately $193.3 million. Based on current estimates, we expect the aggregate amount of dividends that may be paid by our insurance company and HMO subsidiaries to our parent company in 2017 without prior approval by state regulatory authorities is approximately $23 million.

Risk-Based Capital and Minimum Capital Requirements

Risk-based capital requirements promulgated in each state take into account asset risks, interest rate risks, mortality and morbidity risks and other relevant risks with respect to the insurer's business and specify varying degrees of regulatory action to occur to the extent that an insurer does not meet the specified risk-based capital thresholds, with increasing degrees of regulatory scrutiny or intervention provided for companies in categories of lesser risk-based capital compliance. As of December 31, 2016, all of our U.S. insurance company and managed care subsidiaries maintained ratios of total adjusted capital to risk-based capital in excess of the authorized control level. However, should our insurance company and managed care subsidiaries' risk-based capital positions decline in the future, their ability to pay dividends, the need for capital contributions or the degree of regulatory supervision or control to which they are subjected might be affected.

Guaranty Association Assessments

Solvency or guaranty laws of most jurisdictions in which our insurance company subsidiary does business may require them to pay assessments to fund policyholder losses or liabilities of unaffiliated insurance companies that become insolvent. These assessments may be deferred or forgiven under most solvency or guaranty laws if they would threaten an insurer's financial strength and, in most instances, may be offset against future premium taxes. Our insurance company subsidiary provides for known and expected insolvency assessments based on information provided by the National Organization of Life & Health Guaranty Associations. Our insurance company subsidiary has not incurred any significant costs of this nature. The likelihood and amount of any future assessments is unknown and is beyond our control.

Outsourcing Arrangements

We outsource certain processing and administration functions to third parties, subject to outsourcing agreements. The outsourced functions may include membership administration, call center operations, business process outsourcing, revenue management and pharmacy benefit management. In the future, it is possible that we may outsource additional functions or bring in-house one or more of these functions. A summary of our more significant arrangements is presented below.

Business Process Outsourcing

In 2010 we entered into a master services agreement with iGate, now known as Capgemini covering the services iGate provides to us. We continue to use iGate as a business outsource vendor to provide a range of business process services, including, data entry, member application intake and processing, data validation, mailroom imaging and scanning, paper-based and electronic claims adjudication and processing, and overflow labor support services for our Medicare Advantage operations. In addition, iGate also provides certain information technology support and programming. In the future, we may outsource additional services and business processes. Prior to the sale of our Traditional Insurance business in August 2016, the services provided by iGate also included policy administration, underwriting, claims processing and other related processes related to that business.

Membership Administration

We outsource the administrative information technology platform necessary to support our Medicare Advantage businesses to The Trizetto Group. We have entered into an annual support and license agreement, a master hosting services agreement and a consulting services agreement with Trizetto. These agreements collectively support the basic infrastructure surrounding the membership information for our Medicare Advantage business.

Pharmacy Benefit Management

We have entered into a multi-year pharmacy benefits management agreement with CVS Caremark which provides a range of pharmacy benefit management to our Medicare Advantage plans.

Employees

As of February 8, 2017, we employed 850 employees, none of whom is represented by a labor union in such employment. We consider our relations with our employees to be good.

Additional Information

We were incorporated under the laws of the State of Delaware on December 22, 2011. Our common stock is listed on the NYSE under the ticker symbol "UAM." Our corporate headquarters are located at 44 South Broadway, White Plains, New York 10601 and our telephone number is (914) 934-5200.

ITEM 1A—RISK FACTORS

Investors in our securities should carefully consider the risks described below and other information included in this report. This report contains both historical and forward-looking statements. We are making the forward-looking statements within the meaning of Section 27A of the Securities Act and Section 21E of the Exchange Act. We intend the forward-looking statements in this report or made by us elsewhere to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with and relying upon these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including, among other things, the information discussed below. The risks and uncertainties described below are not the only ones that we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our business. In making these statements, except as required by applicable securities laws, we are not undertaking to address or update each factor in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results. If any of the following risks or uncertainties develops into actual events, this could significantly and adversely affect our business, prospects, financial condition and operating results. In that case, the trading price of our common stock could decline materially and investors in our securities could lose all or part of their investment.

Risks Related to the WellCare Merger

The proposed Merger may not be completed on a timely basis, or at all, and the failure to complete the Merger could adversely affect our business and the market price of our common stock.

On November 17, 2016, we entered into an Agreement and Plan of Merger (the "Merger Agreement") with WellCare Health Plans, Inc., a Delaware corporation ("WellCare"), and Wind Merger Sub, Inc. a Delaware corporation and an indirect wholly owned subsidiary of WellCare, pursuant to which Merger Sub will merge with and into the Company (the "Merger") and certain other transactions will be effected with the Company surviving as an indirect wholly owned subsidiary of WellCare. This transaction is referred to as the WellCare Transaction. Although we have received approval of the Merger from our stockholders, the Merger remains subject to various other closing conditions, including the receipt of approvals from Texas and New York insurance regulators. The Company or WellCare may be unable to obtain the necessary approvals or otherwise satisfy the conditions required to complete the WellCare Transaction on a timely basis or at all. If any condition to the closing of the Merger is neither satisfied nor waived, the Merger may not be completed. There can be no assurance that any of the remaining conditions to closing will be satisfied or waived or that other events will not intervene, delay or result in a failure to complete the Merger. Failure to complete the Merger could materially and adversely affect our business and the market price of our common stock in a number of ways, including, but not limited to, the following:

- If the Merger is not completed, and there are no other parties willing and able to acquire the Company for consideration that is equivalent or more attractive than that in the Merger Agreement, on terms acceptable to us, our stock price may decline significantly.

- We have incurred, and will continue to incur, significant costs, expenses and fees for professional services and other transaction costs in connection with the proposed Merger, for which we will have received little or no benefit if the Merger is not completed. Many of these fees and costs will be payable by us even if the Merger is not completed and may relate to activities that we would not have undertaken other than to complete the Merger.

The Merger Agreement prohibits us from pursuing alternative transactions to the Merger.

The Merger Agreement prohibits us from soliciting, initiating and knowingly facilitating or encouraging any inquiries regarding, or the making of any proposal or offer that constitutes, or that could reasonably be expected to lead to, an alternative acquisition proposal from any third party. This provision prevents us from seeking offers from other possible acquirers that may be superior to the pending Merger. In addition, we do not have the ability to terminate the Merger Agreement in order to accept a superior proposal since our stockholders have voted to approve the adoption of the Merger Agreement.

The proposed Merger could adversely affect our business, financial condition and results of operations.

The Merger Agreement includes restrictions on the conduct of our business prior to the completion or termination of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of specified limitations absent WellCare's prior written consent. This may result in our inability to take certain actions that we believe are in the best interests of the Company. In addition, the proposed Merger could cause disruptions in and create uncertainty surrounding our ongoing business operations, which could have an adverse effect on our financial condition and results of operations, regardless of whether the Merger is completed. These risks to our business and operating results include, but are not limited to the following, all of which could be exacerbated by a delay in the completion of the Merger:

- the diversion of significant management time and resources towards the completion of the Merger, including ongoing integration efforts;
- the impairment of our ability to motivate, retain and hire key personnel, including our senior management;
- difficulties maintaining relationships with doctors, hospitals and other health care providers, members, beneficiaries, agents, vendors and others with whom we conduct business; and
- the outcome of any legal proceeding that may be instituted against the Company or others relating to the Merger Agreement and the costs related thereto.

Risks Related to our Business

The Affordable Care Act, or ACA, and subsequent rules promulgated by CMS, including any repeal, replacement or modification to the ACA, could have a material adverse effect on our business and financial results.

The ACA was signed into law in March 2010 and legislated broad-based changes to the U.S. health care system which continue to have a material impact on our business. There is considerable discussion within the new Presidential administration and Congress about repealing and replacing the ACA. At this time, it is uncertain whether, when, and what changes will be made to the ACA, and what impact such changes could have on our business. However, any changes to the ACA, including through any repeal and replacement to the ACA, could have a material adverse effect on our business, financial position and results of operations.

Due to the complexity of the ACA, the final impact remains difficult to predict and quantify. In addition, we believe that any impact from the health reform legislation could potentially be mitigated by certain actions we may take in the future including modifying future Medicare Advantage bids to compensate for such changes. For example, the anticipation of additional revenues from Star bonuses or reduced CMS reimbursement rates are factored into the anticipated level of benefits included in our Medicare Advantage bids for the upcoming year. However, we will need to dedicate significant resources and expense to complying with these new rules and there is a possibility that this legislation could have a material adverse effect on our business, financial position and results of operations.

The provisions of these new laws include the following key points, which are discussed further below:

- reduced Medicare Advantage reimbursement rates, beginning in 2012;
- implementation of a quality bonus for Star Ratings beginning in 2012;
- accountable care organizations, beginning in 2012;
- limitation on the federal tax deductibility of compensation earned by individuals for certain types of companies, beginning in 2013;
- stipulated minimum medical loss ratios, or MLRs, beginning in 2014;
- non-deductible health insurance industry fee, beginning in 2014; and
- coding intensity adjustments, with mandatory minimums beginning in 2014.

Reduced Medicare Advantage reimbursement rates—Beginning in 2012, the Medicare Advantage "benchmark" rates transition to target Medicare fee-for-service cost benchmarks of 95%, 100%, 107.5% or 115% of the calculated Medicare fee-for-service costs. The transition period is 2, 4 or 6 years depending upon the applicable county and 2017 will be the final transition year. The counties are divided into quartiles based on each county's fee-for-service Medicare costs. We estimate that approximately 61%, 32% and 6%, respectively, of our January 1, 2017 membership resides in counties where the Medicare Advantage benchmark rate will equal 95%, 115%, and 107.5%, respectively, of the calculated Medicare fee-for-service costs.

Medicare Advantage payment benchmarks have been cut over the last several years, with additional funding reductions to be phased in as noted above. On February 1, 2017, CMS issued its 2018 Advance Notice and Draft Call Letter (the "Advance Notice") detailing preliminary 2018 Medicare Advantage benchmark payment rates. As is customary, CMS has invited public comment on these preliminary rates before issuing its final rates for 2018 in April 2017. The Advance Notice proposes to provide a slight overall increase to Medicare rates for 2018 and we are continuing to evaluate the overall impact in our markets. At this time, CMS is not implementing any major proposed policy changes with respect to the exclusion of in-home health risk assessments for risk adjustment purposes. If implemented, such change would result in significant additional funding declines for the Company. We will continue to evaluate proposed changes detailed in the Advance Notice, some of which could adversely affect our plan benefit designs, market participation, growth prospects and earnings potential for our Medicare Advantage plans in the future.

To address any rate reductions, we may have to reduce benefits (to the extent permitted), increase member premiums, modify existing operations, reduce profit margins, or implement some combination of these actions. Such actions could have a material adverse effect on our business by:

- Limiting our ability to maintain our current membership levels;
- Making our products less competitive or attractive to prospective members;
- Causing us to exit many service areas;
- Causing us to increase member premiums, lower benefits or impose higher member contributions (e.g., copayments); and
- Require more intensive medical and operating cost management in order to respond to the lower reimbursements.

Continued reductions of Medicare Advantage payment rates may result in Medicare Advantage being no longer economically viable for us in many markets. There can be no assurance that we will be able to execute successfully on these or other strategies to address changes in the Medicare Advantage

program. There can be no assurance that we will be able to successfully address such rate freezes/reductions and failure to do so may result in a material adverse effect on our results of operations, financial position, and cash flows.

Implementation of quality bonus for Star Ratings—Beginning in 2012, Medicare Advantage plans with an overall "Star rating" of three or more stars (out of five) based on historical performance are eligible for a "quality bonus" in their basic premium rates. Plans receiving Star bonus payments are required to use the additional dollars to provide "extra benefits" for the plans' enrollees to the extent necessary to maintain compliance with minimum loss ratio requirements resulting in a competitive advantage for those plans rather than a direct financial impact. In addition, beginning in 2012, Medicare Advantage Star ratings affect the rebate percentage available for plans to provide additional member benefits (plans with quality ratings of 3.5 stars or above will have their rebate percentage increased from a base rate of 50% to 65% or 70%). In all cases, this rebate percentage is lower than the pre-ACA rebate percentage of 75%. Beginning in 2015, in order to qualify for bonus payments, plans must have a 4 Star rating or higher. For 2017, the Company earned a 4.5 Star rating for its flagship TexanPlus® plan in Houston/Beaumont, which accounts for 57% of our December 31, 2016 membership, and maintained a 4 Star rating for our Today's Options PPO plan in New York and Maine. Collectively, over 70% of our members are in Plans with a Star rating of 4.0 or greater.

Notwithstanding continued efforts to improve or maintain our Star ratings and other quality measures, there can be no assurances that we will be successful. Accordingly, our plans may not be eligible for full level quality bonuses or increased rebates, which could adversely affect the benefits such plans can offer, reduce membership, and reduce profit margins.

In addition, CMS has indicated that plans with a Star rating of less than 3.0 for three consecutive years may be subject to termination. While we do not currently have any plans with a rating below 3.0, our inability to maintain Star ratings of 3.0 or better for a sustained period of time could ultimately result in plan termination by CMS which could have a material adverse impact on our business, cash flows and results of operations. Also, the CMS Star ratings/quality scores may be used by CMS to pay bonuses to Medicare Advantage plans that enable those plans to offer improved benefits and/or better pricing. Furthermore, lower quality scores compared to our competitors may result in us losing potential new business in new markets or dissuading potential members from choosing our plan in markets in which we compete. Lower quality scores compared to our competitors could have a material adverse effect on our rate of growth.

Accountable Care Organizations—The ACA established Accountable Care Organizations, or ACOs, as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service program. CMS established the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. To date, we have partnered with numerous groups of healthcare providers and currently participate in sixteen MSSP ACOs and two Next Generation ACOs. ACOs are entities that contract with CMS to serve the Medicare fee-for-service population with the goal of better care for individuals, improved health for populations and lower costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. We provide a variety of services to the ACOs, including care coordination, analytics and reporting, technology and other administrative services to enable these physicians and their associated healthcare providers to deliver better quality care, improved health and lower healthcare costs for their Medicare fee-for-service patients.

To date, we have invested significant capital into our ACO business and have not made money. We expect to continue to invest significant amounts into this business in 2017 and there can be no assurance that we will recoup any of these costs.

Under the MSSP, CMS has not made any payments to ACOs for a measurement year until the second half of the following year, which negatively impacts our cash flows. In order to receive revenues from CMS under the MSSP, the ACO must meet certain minimum savings rates (i.e. save the federal government money) and meet certain quality measures. More specifically, an ACO's medical expenses for its assigned beneficiaries during a relevant measurement year must be below the benchmark established by CMS for such ACO. On the quality side, for 2017, the MSSP requires ACOs to meet thirty-one quality measures, which CMS may vary from time to time. Notwithstanding our efforts, our ACOs may be unable to meet the required savings rates or may not satisfy the quality measures, which may result in our receiving no revenues and losing our substantial investment. In addition, as the MSSP is a new program, it presents challenges and risks associated with the timeliness and accuracy of data and interpretation of complex rules, which may impact the timing and amount of revenue we can recognize and could have a material adverse effect on our ability to recoup any of our investment in this new business. Further, there can be no assurance that we will maintain positive relations with our ACO partners which may result in certain of the ACOs terminating our relationship, which will result in a potential loss of our investment. We continue to evaluate our portfolio of ACOs based on a variety of factors, including the level of commitment by the physicians in the ACO and the likelihood of the ACO achieving shared savings. Based on this evaluation, we have reduced the number of our ACOs and may further reduce the number of our ACOs in the future.

On June 4, 2015, CMS released a final rule updating provisions related to the MSSP in the second contract period for years 2016-2019. This final rule made several changes, including allowing ACOs to participate in Track 1 for a second agreement period with the same sharing rate (up to 50%), establishing a new Track 3 with two-sided risk with additional flexibilities, providing new beneficiary-level claims data that will improve overall ACO information, and easing certain administrative requirements.

Additionally, the CMS Center for Medicare and Medicaid Innovation, or CMMI, launched the Next Generation ACO Model, a new value-based payment model that encourages providers to assume greater risk and provides enhanced rewards for coordinating the healthcare of Medicare fee-for-service beneficiaries. The Next Generation ACO Model provides ACOs with additional tools not found in the MSSP but used in the Medicare Advantage program to improve quality and lower cost, including preferred networks, negotiated discounts and beneficiary incentives. The Next Generation ACO Model offers two risk arrangements with prospectively assigned beneficiaries under which a Next Generation ACO can share up to 80% or 100% of savings (losses) generated in each performance year depending on the financial arrangement selected by the ACO.

For 2017, three of our ACOs have selected Track 2 which involves two-sided risk. In addition, we have two Next-Generation Model ACOs which also involve two-sided risk. This means that the ACO will be financially responsible to the extent that actual medical expenditures of the ACO beneficiaries are higher than the ACOs benchmark. There can be no assurance that any of our ACOs will achieve savings in 2016, 2017 or thereafter, which could result in substantial financial losses.

In June 2016, CMS issued its final rule with respect to changes in the MSSP benchmarking methodology, among other changes. The new rule will gradually incorporate regional expenditure data into rebased benchmarks over the course of multiple three-year ACO agreement periods. CMS finalized an approach that treats ACOs differently depending on whether they have spending higher or lower than that of their region but all benchmarks would eventually incorporate 70 percent regional expenditure data. CMS may issue additional rules or guidance which may materially and adversely affect our ACOs' ability to achieve shared savings, resulting in an adverse effect on our financial performance.

In addition, CMS, the US Office of Inspector General, the Internal Revenue Service, the Federal Trade Commission, the US Department of Justice, and various states have adopted or are considering adopting new legislation, rules, regulations and guidance relating to formation and operation of ACOs.

Such laws may, among other things, require ACOs to become subject to financial regulation such as maintaining deposits of assets with the states in which they operate, the filing of periodic reports with the insurance department and/or department of health, or holding certain licenses or certifications in the jurisdictions in which the ACOs operate. Failure to comply with legal or regulatory restrictions may result in CMS terminating an ACOs agreement with CMS and/or subjecting an ACO to loss of the right to engage in some or all business in a state, payment of fines or penalties, or may implicate federal and state fraud and abuse laws relating to anti-trust, physician fee-sharing arrangements, anti-kickback prohibitions or prohibited referrals, any of which may adversely affect our operations and/or profitability.

Stipulated Minimum MLRs—Beginning in 2014, the ACA stipulates a minimum MLR of 85% for Medicare Advantage plans. This MLR which is calculated at a plan level, takes into account benefit costs, quality initiative expenses, the ACA Fee and taxes. Financial and other penalties may result from failing to achieve the minimum MLR ratio. For the years ended December 31, 2016, 2015 and 2014 our Medicare Advantage plans exceeded the minimum MLR, as defined by CMS. Complying with such minimum ratio by increasing our medical expenditures or refunding any shortfalls to the federal government could have a material adverse effect on our operating margins, results of operations, and our statutory capital.

Non-deductible health insurance industry fee ("ACA Fee")—Beginning in 2014, the new healthcare reform legislation imposed an annual aggregate health insurance industry fee of $8.0 billion, increasing to $11.3 billion in 2015 and 2016 (with increasing annual amounts thereafter) on health insurance premiums, including Medicare Advantage premiums, that is not deductible for income tax purposes. In 2017, the ACA Fee has been suspended for one year. Our share of the ACA Fee is based on our pro rata percentage of premiums written during the preceding calendar year compared to the industry as a whole, calculated annually. The ACA Fee, first expensed and paid in 2014, adversely affects the profitability of our Medicare Advantage business and could have a material adverse effect on our results of operations. For our continuing operations, we paid fees of $21.7 million, $25.5 million and $22.9 million in the years ended December 31, 2016, 2015 and 2014, respectively, based on prior year net written premiums. We do not expect to pay any fees in 2017, due to the one year suspension of the ACA Fee. Pursuant to U.S. GAAP, the liability for the ACA Fee will be estimated and recorded in full once the entity provides qualifying health insurance in the corresponding period with a corresponding deferred cost that is to be amortized to expense on a straight-line basis over the applicable calendar year. For statutory reporting purposes, the ACA Fee will be expensed on January 1 in the year of payment, rather than amortized to expense over the year. The ACA Fee is included in other operating costs; however, will be factored in when calculating the stipulated minimum MLR. Our effective income tax rate increased in 2014 as a result of the ACA Fee, and will remain at a higher level in future years in which the ACA Fee is assessed. In addition, because the ACA Fee is not deductible for federal income tax purposes and we are a smaller company than our peers with smaller revenues and with smaller profits, our effective tax rate is likely to be significantly higher than that of our peers.

Coding intensity adjustments—Under the ACA, the coding intensity adjustment instituted in 2010 became permanent, resulting in mandated minimum reductions in risk scores of 4.91% in 2014 increasing each year to 5.91% in 2018. These coding adjustments may adversely affect the level of payments from CMS to our Medicare Advantage plans.

Limitation on the federal tax deductibility of compensation earned by individuals—Beginning in 2013, with respect to services performed during 2010 and afterward, for health insurance companies, the federal tax deductibility of compensation is limited under Section 162(m)(6) of the Code to $500,000 per individual and this limitation does not contain an exception for "performance-based compensation." In September 2014, the Internal Revenue Service issued final regulations on this compensation deduction limitation which provided additional information regarding the definition of a health

insurance issuer. Based on our analysis of the final regulations, we believe we are not subject to the limitation. As a result, during the fourth quarter of 2014, we recorded a tax benefit of $3.2 million related to prior years and $1.7 million related to the first nine months of 2014. Prior to the promulgation of the final regulations, our application of this limitation had increased our effective tax rate by approximately 60 basis points for the year ended December 31, 2013 and 200 basis points for the year ended December 31, 2012. However, there is a risk that the Internal Revenue Service or other regulators may disagree with our interpretation, which could result in higher taxes.

We are subject to extensive government regulation; compliance with laws and regulations is complex and expensive, and any violation of the laws and regulations applicable to us could reduce our revenues and profitability and otherwise adversely affect our operating results and/or impact our ability to participate in Government programs such as Medicare, the MSSP and the Next Generation ACO Model.

There is substantial federal and state governmental regulation of our business. Several laws and regulations adopted by the federal government, such as the ACA, the False Claims Act, the Sarbanes-Oxley Act of 2002, the Gramm-Leach-Bliley Act, the Health Insurance Portability and Accountability Act of 1996, which we refer to as HIPAA, the Health Information Technology for Economic and Clinical Health Act (HITECH Act), the Medicare Modernization Act, the USA PATRIOT Act, anti-kickback laws, Medicare Improvements for Patients and Providers Act and "Do Not Call" regulations, and their state equivalents have created administrative and compliance requirements for us. The requirements of these laws and regulations are continually evolving, and the cost of compliance may have an adverse effect on our operations and profitability. The evolution of existing laws, rules, or regulations, their enforcement, or changes in their application or interpretation, as well as new laws and regulations could materially and adversely affect our operations, financial position, or results of operations and may expose us to increased liability. As laws and regulations evolve, the costs of compliance, which are already significant, will tend to increase. If we fail to comply with existing or future applicable laws and regulations we could suffer civil, criminal or administrative penalties, including termination of our contracts with CMS. Different interpretations and enforcement policies of these laws and regulations could subject our current practices to allegations of impropriety or illegality, or could require us to make significant changes to our operations. In addition, we cannot predict the impact of future legislation and regulatory changes on our business or assure you that we will be able to obtain or maintain the regulatory approvals required to operate our business. In addition, we are subject to potential changes in the political environment that can affect public policy and can adversely affect the markets for our products.

Laws and regulations governing Medicare and other state and federal healthcare and insurance programs are complex and subject to significant interpretation. As part of the ACA, CMS, State regulatory agencies and other regulatory agencies have been exercising increased oversight and regulatory authority over our Medicare and other businesses. Compliance with such laws and regulations is subject to CMS audit, other governmental review and investigation, including SEC investigations, and significant and complex interpretation. CMS audits our Medicare Advantage plans with regularity to ensure we are in compliance with applicable laws, rules, regulations and CMS instructions. Our Medicare Advantage plans will likely be subject to an audit in 2017. There can be no assurance that we will be found to be in compliance with all such laws, rules and regulations in connection with these audits, reviews and investigations, and at times we have been found to be out of compliance. Failure to be in compliance can subject us to significant regulatory action including significant fines, penalties, cancellation of contracts with governmental agencies or operating restrictions on our business, including, without limitation, suspension of our ability to market to and enroll new members in our Medicare plans, termination of our contracts with CMS, exclusion from Medicare and other state and federal healthcare programs and inability to expand into new markets or add new products within existing markets.

Certain of our subsidiaries provide products and services to various government agencies. As a government contractor, we are subject to the terms of the contracts we have with those agencies and applicable laws governing government contracts. As such, we may be subject to False Claim Act litigation (also known as qui tam litigation) brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government.

Laws in each of the states in which we operate our health plans, insurance companies and other businesses also regulate our sales practices, operations, the scope of benefits, rate formulas, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. These state regulations generally require, among other things, prior approval or notice of new products, premium rates, benefit changes and specified material transactions, such as dividend payments, purchases or sales of assets, inter-company agreements, and the filing of various financial and operational reports.

We are also subject to various governmental reviews, audits and investigations, including SEC investigations, to verify our compliance with our contracts and applicable laws and regulations. State departments of insurance routinely audit our health plans and insurance companies for financial and contractual compliance. State departments of health audit our health plans for compliance with health services. State attorneys general, the SEC, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, the Government Accountability Office, state departments of insurance and departments of health and Congressional committees may also conduct audits and investigations of us. We have historically incurred, and expect to continue to incur, significant costs to respond to governmental reviews, audits and investigations, and we expect these costs to increase over time as regulation increases and becomes more complex and as regulatory agencies and Congressional committees become more sophisticated and thorough.

Any adverse review, audit or investigation, or changes in regulations resulting from the conclusion of reviews, audits or investigations, could result in:

- repayment of amounts we have been paid pursuant to our government contracts;
- imposition of civil or criminal penalties, fines or other sanctions on us;
- loss of licensure or the right to participate in Medicare and other government-sponsored programs;
- suspension of marketing and enrollment privileges;
- damage to our reputation in various markets;
- legislative or regulatory changes that affect our business and operations;
- increased difficulty in marketing our products and services; and
- prohibiting the expansion to new markets or the addition of new products in existing markets.

Any of these events could make it more difficult for us to sell our products and services, reduce our revenues and profitability and otherwise adversely affect our reputation and/or operating results. CMS from time to time releases proposed or amended rules, regulations, and guidance that, if adopted, would, among other things, place tighter restrictions on marketing processes relative to the Medicare Advantage program and Medicare prescription drug benefit program. Depending upon the final content of these regulations, if CMS proposes and adopts them, compliance with and enforcement of the regulations could have a material adverse effect on our results of operations.

We are also subject to a federal law commonly referred to as the "Anti-Kickback Statute." The Anti-Kickback Statute prohibits the payment or receipt of any "Remuneration" that is intended to induce referrals or the purchasing, leasing or ordering of any item or service that may be reimbursed,

in whole or in part, under a Federal Health Care Program, such as Medicare. It also prohibits the payment or receipt of any remuneration that is intended to induce the recommendation of the purchasing, leasing or ordering of any such item or service. Violations of such statute or other laws could result in substantial monetary penalties and could also include exclusion from the Medicare program.

In addition, in connection with the establishment of the MSSP and the Next Generation ACO Model, the relevant federal agencies issued waivers of certain laws governing potential fraud and abuse involving federal health care program beneficiaries (e.g. the Stark Law, Civil Monetary Penalties Law, and the Anti-Kickback Statute). These waivers have been and may be modified, altered, restricted, or otherwise changed from time to time by the relevant federal agencies. The objective of the federal waivers is to foster innovative financial arrangements that will assist an ACO in meeting the goals of the MSSP or Next Generation ACO Model. As part of our ACO business, we enter into arrangements with various third parties such as laboratory companies and other providers, that are intended to be covered by such waivers. Further, state regulators or agencies may not recognize the federal waivers and view such arrangements as violating state laws. There can be no assurances that we may not be subject to state or federal action with respect to any arrangement purported covered by the waivers. However, if such arrangements are found not to be covered by such waivers, we may be subject to substantial penalties and/or fines and could be precluded from participating in government programs such as the MSSP or Next Generation ACO Model. Further, the restriction or modification of any waivers or the imposition of state action may require our ACOs to terminate certain arrangements which may result in a material adverse effect on our financial results.

If we fail to effectively design and price our products properly and competitively, if the premiums and fees we charge are insufficient to cover the cost of health care services delivered to our members, or if our estimates of benefit expenses are inadequate, our profitability may be materially adversely affected.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers, and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Our premiums for our Medicare Advantage business are fixed for one-year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to payment patterns and medical cost trends. The profitability of our risk-based products depends in large part on our ability to predict, price for and effectively manage medical costs. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. In addition, we have and may continue to pursue additional opportunities in the Medicaid risk business, which presents additional challenges around pricing and underwriting. Failure to adequately price our products or estimate medical costs may result in a material adverse effect on our business, cash flows and results of operations.

In addition, during 2015, we significantly grew our Medicare Advantage membership in our Northeast markets, increasing membership by approximately 35%. We incurred losses in 2015 in our Northeast Medicare Advantage markets as a result of higher than expected utilization and a lag in adequate premium for our new members. While we have taken steps to address these issues, there can be no assurance that we will be able to sustain profitably in these markets.

Reductions in funding for Medicare programs could materially reduce our ability to achieve profitability.

We generate virtually all our revenue from the operation of our Medicare Advantage plans and our ACOs. As a result, our revenue and profitability are dependent, in part, on government funding levels for all of these various programs. The rates paid to Medicare Advantage health plans like ours are established by contract, although the rates differ depending on a combination of factors, such as upper payment limits established by CMS, a member's health profile and status, age, gender, county or region, benefit mix, member eligibility categories and the plan's risk scores. Future Medicare rate levels and overall funding for Medicare, may be affected by continuing government efforts to contain and/or reduce overall medical expenses, including the Advance Notice and Draft Call Letter described above, and other budgetary and fiscal constraints. The government is continuously examining Medicare Advantage health plans like ours in comparison to Medicare fee-for-service payments, and this examination could result in a reduction in payments to Medicare Advantage health plans like ours. Changes in the Medicare program or funding may affect our ability to operate under the Medicare program or lead to reductions in the amount of reimbursement, eliminate coverage for some benefits or reduce the number of persons enrolled in or eligible for Medicare or increase member premium.

Failure to control and/or reduce our administrative operating costs could have a material adverse effect on our financial position, results of operations and cash flows.

The level of our administrative operating costs significantly affects our profitability. During 2016, our administrative expense ratio in our Medicare Advantage business was 11.2%. Beginning in 2014, Medicare Advantage plans are required to meet an 85% medical loss ratio and we are subject to a non-deductible insurance industry fee, which is suspended for 2017, that is approximately 1.6% of premium for 2016. Thus, in order to generate meaningful earnings, we will need to continue to reduce our administrative operating expenses from current levels. We are smaller than many of our competitors which makes it harder to reduce administrative operating expenses. Reducing administrative expenses has and may continue to require us to reduce our headcount, which can place significant strains on our operations. If we are unable to reduce our administrative operating expenses to better match our smaller size, or if we are unable to effectively manage operating our business with a reduced headcount, it could have a material adverse effect on our financial condition, results of operations and cash flows.

A significant portion of our revenue is tied to our Medicare businesses and regulated by CMS and if our government contracts are not renewed or are terminated, our business would be substantially impaired.

We earn most of our revenue from our Medicare Advantage businesses in which CMS is not only our largest customer but also our regulator. If we are unable to maintain a constructive relationship with CMS, our business could suffer materially. As a government contractor, we provide our Medicare Advantage benefits and other services through a limited number of contracts with federal government agencies. These contracts generally have terms of one to three years and are subject to non-renewal by the applicable agency. All of our government contracts are terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. In addition, a government agency may suspend our right to add new members if it finds deficiencies in our provider network or operations, as was the case for a significant portion of the 2011 selling season as a result of CMS sanctions. If we are unable to renew, or to successfully re-bid or compete for any of our government contracts, or if any of

our contracts are terminated, our business could be substantially impaired. If any of those circumstances were to occur, we would likely pursue one or more alternatives, such as

- seeking to enter into contracts in other geographic markets;
- seeking to enter into contracts for other services in our existing markets; or
- seeking to acquire other businesses with existing government contracts.

If we were unable to do so, we could be forced to cease conducting business. In this event, our revenues and profits would decrease materially.

Competition in the healthcare industry is intense, and if we do not design and price our products properly and competitively, our membership and profitability could decline.

We operate in a highly competitive industry. Some of our competitors have more established businesses with larger market share, more established reputations and brands and greater financial resources than we have in some markets. In addition, other companies may enter our markets in the future. Medicare Advantage plans are generally bid upon or renewed annually. We compete for members on the basis of the following and other factors:

- price;
- the size, location, quality and depth of provider networks;
- benefits provided;
- quality and extent of services; and
- reputation.

In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reforms and marketing practices create pressure to contain premium rate increases, despite being faced with increasing medical costs. Premium increases, introduction of new product designs, our relationship with our providers in various markets, and our possible exit from or entrance into markets, among other issues, could also affect our membership levels.

We compete based on innovation and service, as well as on price and benefit offering. We may not be able to develop innovative products and services which are attractive to clients. Moreover, although we need to continue to expend significant resources to develop or acquire new products and services in the future, we may not be able to do so. We cannot be sure that we will continue to remain competitive, nor can we be sure that we will be able to market our products and services to clients successfully at current levels of profitability.

Consolidation within the industries in which we operate may lead to increased competition. Strategic combinations involving our competitors could have an adverse effect on our business or results of operations.

Our business strategy is evolving and may involve pursuing new lines of business or strategic transactions and investments, some of which may not be successful.

The healthcare industry is undergoing significant change and our business strategy is continuing to evolve to meet these changes. In order to profitably grow our business, we may need to expand into new lines of business beyond our historical core of providing managed care and health insurance products, which may involve pursuing strategic transactions, including potential acquisitions of, or investments in, related or unrelated businesses. In addition, we may seek a variety of strategic transactions, including, without limitation, divestitures of existing businesses or assets, a merger or

consolidation with a third party that results in a change in control (such as the WellCare Transaction), a sale or transfer of all or a significant portion of our assets or a purchase by a third party of our securities that may result in a minority or control investment by such third party.

For example, over the past several years we partnered with groups of providers to form numerous ACOs and have invested significant capital into this business. While our ACO business continues to improve, it has lost money since inception. Going forward, we may pursue additional opportunities in the healthcare sector which may involve us providing capital and/or reinsurance to health plans. We may also pursue various strategic transactions with providers, independent practice associations and other provider groups, including acquisitions, joint ventures and other arrangements. Each of these opportunities may require the investment of significant capital and management attention. There can be no assurance that we will be successful with any of these potential new ventures and we could suffer significant losses as a result, which could have a material adverse effect on our business, financial condition and results of operations.

We may finance future acquisitions, investments or opportunities through available cash, equity issuances or through the incurrence of additional indebtedness. Future acquisitions or investments, and the incurrence of additional indebtedness, could subject us to a number of risks, including, but not limited to:

- the assumption of contingent liabilities;
- potential losses from unanticipated litigation, undiscovered or undisclosed liabilities or unanticipated levels of claims, relating to either the pre- or post-acquisition periods;
- risks and uncertainties associated with transaction counterparties;
- the loss of key personnel and business relationships;
- difficulties associated with assimilating and integrating new personnel, assets, intellectual property and operations of an acquired company or business;
- the distraction of our management from existing programs and initiatives in pursuing such strategic transactions; and
- where indebtedness is incurred, general risks associated with higher leverage, including increased debt service obligations, reduced liquidity and reduced access to capital markets.

In addition, any strategic transaction that we may pursue may not result in anticipated benefits to us and may result in unforeseen costs that, in each case, may adversely impact our financial condition and results of operations.

Changes in governmental regulation or legislative reform could increase our costs of doing business and adversely affect our profitability.

The federal government and the states in which we operate extensively regulate our various businesses. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than shareholders. From time to time, Congress has considered various forms of "Patients' Bill of Rights" legislation, which, if adopted, could alter the treatment of coverage decisions under applicable federal employee benefits laws. There have also been legislative attempts at the state level to limit the preemptive effect of federal employee benefits laws on state laws. If adopted, these types of limitations could increase our liability exposure and could permit greater state regulation of our operations. The government agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact

with our policyholders, members, providers and the public. Healthcare laws and regulations are subject to frequent change and differing interpretations.

In addition, changes in the political climate or in existing laws or regulations, or their interpretations, or the enactment of new laws or the issuance of new regulations, including the repeal, replacement and/or modification to the ACA could adversely affect our business by, among other things:

- imposing additional license, registration, or capital reserve requirements;
- increasing our administrative and other costs;
- forcing us to undergo a corporate restructuring;
- increasing mandated benefits without corresponding premium increases;
- limiting our ability to engage in inter-company transactions with our affiliates and subsidiaries;
- adversely affecting our ability to operate under the Medicare program and to continue to serve our members and attract new members;
- changing the manners or the basis upon which CMS reinsures us or pays premium to us, or upon which our members pay premiums;
- forcing us to alter or restructure our relationships with providers and agents;
- restricting our ability to market our products;
- increasing governmental regulation or provision of healthcare services;
- requiring that health plan members have greater access to non-formulary drugs;
- expanding the ability of health plan members to sue their plans;
- requiring us to implement additional or different programs and systems; and
- prohibiting us from participating in existing or future programs and systems.

While it is not possible to predict when and whether fundamental policy changes would occur, policy changes on the local, state and federal level could fundamentally change the dynamics of our industry, such as policy changes mandating a much larger role of the government in the health care arena. Changes in public policy could materially affect our profitability, our ability to retain or grow business, or our financial condition. State and federal governmental authorities are continually considering changes to laws and regulations applicable to us which could result in new regulations that increase the cost of our operations or otherwise have a material adverse effect on our business and results of operations.

Compliance with and enforcement of the existing and any proposed regulations could have a material adverse effect on our results of operations.

If we fail to properly maintain the integrity of our data and information systems and we sustain a cyber-attack or other data security or privacy breach, we could incur significant regulatory fines or penalties, significant damage to our reputation and our business and results of operations could be materially adversely affected.

Cybersecurity attacks and data security breaches have become increasingly common, particularly in the healthcare industry. While we take precautions to prevent such attacks, there can be no assurance that we or one of our vendors or other third parties that have access to our information will not be subject to an attack or breach in the future. Our business depends significantly on efficient, effective and secure information systems and the integrity and timeliness of the data we use to run

our business.

We have various information systems that support our operating segments. The information gathered and processed by our management information systems assists us in, among other things, marketing and sales tracking, underwriting, billing, claims processing, medical management, medical care cost and utilization trending, financial and management accounting, reporting, planning and analysis and e-commerce. These systems also support on-line customer service functions, provider and member administrative functions and support tracking and extensive analyses of medical expenses and outcome data.

Cybersecurity attacks can arise in a variety of manners, including from third parties who may attempt to fraudulently induce employees, vendors, providers or other users of our systems to disclose sensitive information in order to gain access to our data or that of our members or beneficiaries. In addition, while we maintain certain standards for vendors that provide us services, our vendors, and in turn, their own service providers, may become subject to a security breach as a result of their failure to perform in accordance with contractual arrangements.

Our information systems and applications require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses were to be found to be inaccurate or unreliable, if we fail to properly maintain our information systems and data integrity, or if we fail to successfully update or expand processing capability or develop new capabilities to meet our business needs in a timely manner, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, lose our ability to produce timely and accurate reports, have regulatory or other legal problems, have increases in operating and administrative expenses, lose existing customers, have difficulty in attracting new customers or in implementing our business strategies, sustain losses due to fraud or suffer other adverse consequences.

To the extent we fail to maintain effective information systems, we may need to contract for these services with third-party management companies, which may be on less favorable terms to us and significantly disrupt our operations and information flow. In addition, we have outsourced the operation of certain of our data centers to independent third parties and may from time to time obtain and/or outsource additional services or facilities from or to other independent third parties. Dependence on third parties for these services and facilities may make our operations vulnerable to their failure to perform as agreed. In addition, we could be subject to hackers or other forms of cyber-security attacks that bypass our information technology security systems. If a hacker or cyber-security attack were to be successful, we could be adversely affected due to the theft, destruction, loss, misappropriation or release of confidential data, operational or business delays resulting from the disruption of our systems, negative publicity resulting in reputational damage with our members, agents, providers, regulators and other stakeholders and significant fines, penalties and other costs.

Furthermore, our business requires the secure transmission of confidential information over public networks. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches and our business operations and profitability would be adversely affected by cancellation of contracts, loss of members and potential criminal and civil sanctions if they are not prevented.

There can be no assurance that our process of improving existing systems, developing new systems to support our expanding operations, integrating new systems, protecting our proprietary information, and improving service levels will not be delayed or that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data may result in a material adverse effect on our financial positions, results of operations and cash flows.

CMS's risk adjustment payment system, including the manner in which we estimate CMS revenues and the results of any RADV audits and budget neutrality factors, make our revenue and profitability difficult to predict and could result in material retroactive and other adjustments to our results of operations.

All of the Medicare Advantage programs we offer are subject to Congressional appropriation. As a result, our profitability is dependent, in large part, on continued funding for government healthcare programs at or above current levels. The reimbursement rates paid to health plans like ours by the federal government are established by contract, although the rates differ depending on a combination of factors such as a member's health status, age, gender, county or region, benefit mix, member eligibility categories, and the plans' risk scores.

CMS has implemented a risk adjustment model that apportions premiums paid to Medicare Advantage plans according to health severity. The risk adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to Medicare Advantage plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's original Medicare program.

Under the risk adjustment methodology, all Medicare Advantage plans must capture, collect and submit the necessary diagnosis code information from inpatient and ambulatory treatment settings to CMS within prescribed deadlines. The CMS risk adjustment model uses this diagnosis data to calculate the risk adjusted premium payment to Medicare Advantage plans. We generally rely on providers to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. As a result of this process, it is difficult to predict with certainty our future revenue or profitability. CMS may also change the manner in which it calculates risk adjusted premium payments in ways that are adverse to us. For example, in the past, CMS proposed excluding for risk adjustment purposes the diagnosis codes obtained from in-home health risk assessments unless such codes are subsequently validated by a clinical encounter with a qualified provider. Over the past several years, we have utilized in-home health risk assessments for our Medicare Advantage members. Accordingly, if implemented, this change could have a material adverse effect on our payments from CMS and our results of operations. In addition, our own risk scores for any period may result in favorable or unfavorable adjustments to the payments we receive from CMS and our Medicare premium revenue. Because diagnosis coding is a manual process, there is the potential for human error in the recording of codes and there can be no assurance that physicians, hospitals, and other health care providers are submitting accurate codes to us or that they will be successful in improving the accuracy of recording diagnosis code information and therefore our risk scores. There is ongoing litigation in multiple jurisdictions challenging certain Medicare plans' coding practices, the results of which may have a material adverse effect on our business practices and financial results. In addition, CMS continues to evaluate the overall risk adjustment methodology that is used to pay Medicare Advantage plans. Any major changes to this methodology or findings that our coding practices of our providers do not comply with applicable laws, could have a material adverse effect on our profitability.

Beginning in 2008, CMS announced its intention to engage in a pilot program to more extensively audit a select group of Medicare Advantage plans in the area of hierarchical condition category, or HCC, coding for the determination of risk score revenue. These audits were labeled "Risk Adjustment Data Validation" audits, or RADV. RADV audits review medical record documentation in an attempt to validate provider coding practices and the presence of risk adjustment conditions which influence the calculation of premium payments to Medicare Advantage plans. On February 24, 2012, CMS released a final RADV audit and payment adjustment methodology which clarified many of the uncertainties arising from prior proposals. Under the final rule, CMS has indicated that it will now reduce the extrapolated contract level error rate found during the audits based on the error rate found in the

Government's 'benchmark' audit data for Medicare fee-for-service population CMS has begun to conduct RADV audits of select Medicare Advantage plans and our PPO plan offered by American Progressive Life & Health Insurance Company of New York was audited based on 2012 revenue using 2011 dates of service. As of December 31, 2012, this PPO plan had approximately 12,000 members. We have not yet heard from CMS regarding the results of this audit. We are also subject to national RADV audits from time to time. CMS may discover coding errors during these or other RADV audits, which could require us to make significant payments to CMS or require significant payment adjustments, which could have a material adverse effect on our results of operations, financial position and cash flows. On December 22, 2015, CMS issued a proposed statement of work related to a material expansion of RADV audits, with the ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

Coincident with phase-in of the risk-adjustment methodology, CMS also adjusted payments to Medicare Advantage plans by a "budget neutrality" factor. CMS implemented the budget neutrality factor to prevent overall health plan payments from being reduced during the transition to the risk-adjustment payment model. CMS first developed the payment adjustments for budget neutrality in 2002 and began to use them with the 2003 payments. CMS began phasing out the budget neutrality adjustment in 2007 and fully eliminated it in 2011. The risk adjustment methodology and phase-out of the budget neutrality factor will reduce our plans' premiums unless our risk scores increase. We do not know if our risk scores will increase in the future or, if they do, that the increases will be large enough to offset the elimination of this adjustment. As a result of the CMS payment methodology described previously, the amount and timing of our CMS monthly premium payments per member may change materially, either favorably or unfavorably. In addition, the possibility exists that CMS may reduce revenues in the future for plans whose risk scores have increased significantly greater than the general Medicare average increase in risk scores. If our risk scores increase significantly greater than the general Medicare average increase, and CMS introduces this approach, it could adversely affect our results of operations.

In addition, CMS continues to evaluate the overall risk adjustment methodology that is used to pay Medicare Advantage plans. Any changes to this methodology could have a material adverse effect on our financial results. For example, CMS has begun to change the manner in which it calculates risk scores. Historically, CMS has calculated risk scores using diagnosis data from the Risk Adjustment Processing System, or RAPS. However, it is beginning to phase-in the use of diagnosis data from the Encounter Data System, or EDS, in calculating risk scores. The phase-in from RAPS to EDS could result in different risk scores from each dataset, and could have a material adverse effect on our risk scores, resulting CMS premiums and financial results.

In February 2016, CMS finalized rules regarding "overpayments" to Medicare Advantage plans which may arise under a variety of circumstances, including risk adjustment. The failure to report and return overpayments may result in significant potential liabilities under the False Claims Act and the imposition of other administrative penalties by CMS, which could adversely affect our results of operations, financial position, or cash flows. The precise interpretation, impact, and scope of the final rules regarding overpayments are not clear and are subject to pending litigation.

During the quarter ended March 31, 2016, we changed the way we estimate changes in risk-adjusted premiums receivable from CMS based on health diagnoses for our Medicare Advantage business. Under our previous methodology, we estimated changes in CMS premiums related to revenue adjustments based upon the diagnosis data submitted to CMS and ultimately accepted by CMS. We believe this method resulted in a lag in recognizing revenue for changes in our members' medical conditions that will ultimately be included in the final risk adjusted premium paid by CMS. During the first quarter of 2016, we completed the development and validation of a model that allows us to better estimate the risk-adjusted premiums that will ultimately be realized based upon our historical experience for members that have a full year of experience and members that have joined during the

annual enrollment period or special election period. We believe this method serves to better reflect risk-adjusted premiums in the period in which they are earned and is considered a change in estimate under ASC 250, *Accounting Changes.*

This change in estimate resulted in the accelerated recognition of $9.2 million in additional current year premium revenue, or $0.08 per share, after tax for the year ended December 31, 2016. Under our previous estimation process, this revenue would not have been recognized until the related diagnosis data was submitted to and accepted by CMS, typically in the first and second quarters of the subsequent year. If our estimation process is incorrect, it could result in material changes to our previously-reported revenues and profitability for any particular period.

The bidding process for our Medicare Advantage plans may adversely affect our profitability.

Payments for Medicare Advantage health plans are based on a bidding process that may decrease the amount of premiums paid to us or cause us to increase the benefits we offer to our members. We are required to submit Medicare Advantage bids annually, approximately six months in advance of the corresponding benefit year. We attempt to use the best available member eligibility, claims and risk score data at the time of developing the bids. Furthermore, we make actuarial assumptions about the utilization of benefits in our plans and the impact of government regulations. However, these assumptions are subject to significant judgment and we cannot be assured that the data and assumptions used at the time of bid development will prove to be correct and that premiums will be sufficient to cover member benefits plus a reasonable margin. For example, our 2015 bid for our Northeast markets did not appropriately consider the unexpected 35% growth in membership that we experienced during 2015 which resulted in us incurring losses in these markets.

Furthermore, our premiums from CMS relating to any prescription drug benefit are subject to risk corridor payments from or to CMS. Variances from our annual bids to actual prescription drug costs that exceed certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. The estimate of the risk corridor payment requires us to consider factors that may not be certain, including differences in interpretation of data as compared with CMS.

If our bid assumptions are too low and member claims are higher than anticipated, we could be required to expend significant unanticipated amounts and incur losses which could have a material adverse effect on our business, profitability and results of operations.

Because our Medicare Advantage premiums, which generate most of our Medicare Advantage revenues, are fixed by contract, we are unable to increase our Medicare Advantage premiums during the contract term if our corresponding medical benefits expense exceeds our estimates which can adversely affect our results of operations.

Most of our Medicare Advantage revenues are generated by premiums consisting of fixed monthly payments per member. We use a significant portion of our revenues to pay the costs of health care services delivered to our members. The principal costs consist of claims payments, capitation payments and other costs incurred to provide health insurance coverage to our members. Generally, premiums in the health care business are fixed on an annual basis by contract, and we are obligated during the contract period to provide or arrange for the provision of healthcare services as established by the federal government.

We are unable to increase the premiums we receive under these contracts during the then-current term. If our medical expenses exceed our estimates, we generally cannot recover costs we incur in excess of our medical cost projections in the contract year through higher premiums. As a result, our profitability depends, to a significant degree, on our ability to adequately predict and effectively manage our medical expenses related to the provision of healthcare services. Accordingly, the failure to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported claims, known as IBNR, may have a material adverse effect on our financial condition, results of operations, or cash flows. If our estimates of reserves are inaccurate, our ability to take timely corrective actions or to otherwise establish appropriate premium pricing could be adversely affected. Failure to adequately price our products or to estimate sufficient medical claim reserves may result in a material adverse effect on our financial position, results of operations and cash flows. In addition, to the extent that CMS or Congress takes action to reduce the levels of payments to Medicare Advantage providers, our revenues would be adversely affected.

We estimate the costs of our future medical claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, cost trends, product mix, seasonality, medical inflation, historical developments, such as claim inventory levels and claim receipt patterns, and other relevant factors. We continually review estimates of future payments relating to medical claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves. However, historically, our medical expenses as a percentage of premium revenue have fluctuated. The principal factors that may cause medical expenses to exceed our estimates are:

- increased utilization of medical facilities and services;
- increased utilization of prescription drugs (e.g., new treatments or specialty pharmacy drugs such as those associated with treatments for Hepatitis C);
- increased cost of services;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business;
- product changes or benefit level changes;
- periodic renegotiation of hospital, physician and other provider contracts, or the consolidation of these entities;
- membership in markets lacking adequate provider networks;
- changes in the demographics of our members and medical trends affecting them;

- termination of capitation arrangements resulting in the transfer of membership to fee-for-service arrangements or loss of membership;
- the occurrence of acts of terrorism, public health epidemics or other wide spread health emergencies such as higher incidence of the flu, severe weather events or other catastrophes;
- the introduction of new or costly treatments, specialty pharmacy drugs (such as drugs to treat Hepatitis C) and technologies;
- medical cost inflation or changes in the economy;
- government mandated benefits or other regulatory changes;
- contractual disputes with hospitals, physicians and other providers; and
- other unforeseen occurrences.

Because of the relatively high average age of the Medicare population, medical expenses for our Medicare Advantage plans may be particularly difficult to control. We may not be able to continue to manage these expenses effectively in the future. If our medical expenses increase, our profits could be reduced or we may not remain profitable.

We hold reserves for expected claims, which are estimated, and these estimates involve an extensive degree of judgment. If actual claims exceed reserve estimates, our results could be materially adversely affected.

Our benefits incurred expense reflects estimates of IBNR. We, together with our internal and external consulting actuaries, estimate our claim liabilities using actuarial methods based on historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors. Actual conditions, however, could differ from those assumed in the estimation process, and those differences could be material. Due to the uncertainties associated with the factors used in these assumptions, the actual amount of benefit expense that we incur may be materially more or less than the amount of IBNR originally estimated, and materially different amounts could be reported in our financial statements for a particular period under different conditions or using different assumptions. We make adjustments, if necessary, to benefits incurred expense when the criteria used to determine IBNR change and when we ultimately determine actual claim costs. If our estimates of IBNR are inadequate in the future, our reported results of operations will be adversely affected. Further, our inability to estimate IBNR accurately may also affect our ability to take timely corrective actions or otherwise establish appropriate premium pricing, further exacerbating the extent of any adverse effect on our results.

In addition, we may experience higher than expected loss ratios if health care costs exceed our estimates. We seek to take appropriate actions in an effort to reverse any upward trend in our loss ratios; however, we can make no assurances that these actions will be sufficient. We also cannot give assurance that our loss ratios will not continue to increase beyond what we currently anticipate, and any increases could materially adversely affect our results of operations.

We are required to comply with laws governing the transmission, security and privacy of health information that require significant compliance costs, and any failure to comply with these laws could result in material criminal and civil penalties.

Regulations under HIPAA require us to comply with standards regarding the exchange of health information within our company and with third parties, such as healthcare providers, business associates and our members. The HITECH Act broadened the scope of the privacy and security regulations of HIPAA and mandates individual notification in the event of certain breaches of individually identifiable

health information and provides enhanced penalties for HIPAA violations. These regulations impose standards for common healthcare transactions, such as:

- claims information, plan eligibility, and payment information;
- unique identifiers for providers and employers;
- security;
- privacy; and
- enforcement.

HIPAA also provides that to the extent that state laws impose stricter privacy standards than HIPAA privacy regulations, HIPAA does not preempt the state standards and laws.

Given the complexity of the HIPAA regulations, the possibility that the regulations may change, and the fact that the regulations are subject to changing and potentially conflicting interpretation, our ability to maintain compliance with the HIPAA requirements is uncertain and the costs of compliance are significant. Furthermore, a state's ability to promulgate stricter laws, and uncertainty regarding many aspects of state requirements, make compliance more difficult. To the extent that we submit electronic healthcare claims and payment transactions that do not comply with the electronic data transmission standards established under HIPAA, payments to us may be delayed or denied. Additionally, the costs of complying with any changes to the HIPAA regulations may have a negative impact on our operations. We could be subject to criminal penalties and civil sanctions for failing to comply with the HIPAA health information provisions, which could result in the incurrence of significant monetary penalties. In addition, our failure to comply with state health information laws that may be more restrictive than the regulations issued under HIPAA could result in additional penalties.

Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort. HIPAA could also expose us to additional liability for violations by our business associates. A business associate is a person or entity, other than a member of our work force, who on behalf of us performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information, or provides legal, accounting, consulting, data aggregation, management, administrative, accreditation or financial services. Because we are ultimately responsible for many of the acts of our business associates, any failure of such third parties to comply with HIPAA or other privacy regulations could cause us to incur civil or criminal penalties, including significant damage to our reputation.

In 2013, the United States Department of Health and Human Services issued the omnibus final rule on HIPAA privacy, security, breach notification requirements and enforcement requirements under the HITECH Act, and a final regulation for required changes to the HIPAA Privacy Rule for the Genetic Information Nondiscrimination Act, or GINA. Our failure to comply with the omnibus final rule or the failure of our business associates to comply with HIPAA, the HITECH ACT, GINA, or other privacy regulations could cause us to incur civil or criminal penalties, including significant damage to our reputation.

Legal and regulatory investigations and actions are increasingly common in the managed care business and may result in financial losses and harm our reputation.

We face a significant risk of class action lawsuits and other litigation and regulatory investigations and actions in the ordinary course of operating our businesses. Due to the nature of our businesses, we are subject to a variety of legal and regulatory actions relating to our business operations, such as the

design, management and offering of products and services. The following are examples of the types of potential litigation and regulatory investigations we face:

- claims under the False Claims Act or State whistleblower statutes;
- investigations by the SEC;
- claims by government agencies, including CMS, relating to compliance with laws and regulations;
- provider disputes involving our right to properly withhold amounts relating to sequestration and other compensation-related matters, including termination of provider contracts;
- claims relating to sales and marketing practices;
- claims relating to the denial or delay of health care benefit payments;
- claims relating to improper coding;
- challenges to the use of software products used in running our business;
- claims relating to provider marketing;
- anti-kickback claims;
- medical malpractice or negligence actions based on our medical necessity decisions or brought against us on the theory that we are liable for our providers' alleged malpractice or negligence;
- medical malpractice or negligence actions related to the operation of our care management programs;
- allegations of anti-competitive and unfair business activities;
- allegations of discrimination;
- claims related to the failure to disclose business practices;
- allegations of breaches of duties to members or customers;
- allegations of infringement of intellectual property rights of third parties;
- claims relating to inadequate or incorrect disclosure or accounting in our public filings;
- allegations of agent misconduct;
- claims related to deceptive trade practices;
- claims related to the quality of our networks (e.g., credentialing) or the quality of medical services rendered by our providers (e.g., vicarious liability for medical services); and
- claims relating to customer audits and contract performance (including our contracts with CMS for our Medicare Advantage and ACO companies).

As a provider of health insurance, we are subject to the False Claims Act, which provides, in part, that the federal government may bring a lawsuit against any person or entity who it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a

false record to get a claim approved. Violations of the False Claims Act are punishable by treble damages and penalties of up to a specified dollar amount per false claim. In addition, a special provision under the False Claims Act allows a private person (for example, a "whistleblower" such as a disgruntled employee, competitor or member) to bring an action under the False Claims Act on behalf of the government alleging that an entity has defrauded the federal government and permits the private person to share in any settlement of, or judgment entered in, the lawsuit.

Plaintiffs in class action and other lawsuits against us may seek very large or indeterminate amounts, and punitive and treble damages, which may remain unknown for substantial periods of time. We are also subject to various regulatory inquiries, such as information requests, formal and informal inquiries, subpoenas and books and record examinations, from state and federal regulators and other authorities, including the Securities and Exchange Commission. A substantial legal liability or a significant regulatory action against us could have an adverse effect on our business, financial condition and results of operations.

We cannot predict the outcome of actions we face with certainty, and we have incurred and are incurring expenses in the defense of our past and current matters. We also may be subject to additional litigation in the future. Litigation could materially adversely affect our business or results of operations because of the costs of defending these cases, the costs of settlement or judgments against us, or the changes in our operations that could result from litigation. The defense of any these actions may be time-consuming and costly, and may distract our management's attention. In addition, we could suffer significant harm to our reputation, which could have an adverse effect on our business, financial condition and results of operations. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Potential liabilities may not be covered by insurance or indemnity, insurers or indemnifying parties may dispute coverage or may be unable to meet their obligations or the amount of our insurance or indemnification coverage may be inadequate. In some cases, treble damages may be sought. In addition, some types of damages, such as punitive damages or damage for willful acts, may not be covered by insurance. The cost of business insurance coverage has increased, and may in the future increase, significantly. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future. We cannot assure you that we will be able to obtain insurance coverage in the future, or that insurance will continue to be available on a cost-effective basis, if at all.

The health care industry continues to receive significant negative publicity regarding the public's perception of it. This publicity and public perception have been accompanied by increased litigation, in some cases resulting in large jury awards, legislative activity, regulation, and governmental review of industry practices.

These factors, as well as any negative publicity about us in particular, could adversely affect our ability to market our products or services and to attract and retain members, may adversely affect our relationship with providers, may require us to change our products or services, may increase the regulatory burdens under which we operate and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our financial position, results of operations and cash flows.

We rely on the accuracy of information provided by CMS regarding the eligibility of an individual to participate in our Medicare Advantage plans, the list of Medicare fee-for-service beneficiaries assigned to our ACOs, and any inaccuracies in those lists could cause CMS to recoup premium payments from us with respect to members who turn out not to be ours, or could cause us to pay benefits in respect of members who turn out not to be ours, which could reduce our revenue and profitability, or result in us expending resources in attempting to manage the care of such individuals.

Premium payments that we receive from CMS are based upon eligibility lists produced by federal and local governments. From time to time, CMS requires us to reimburse it for premiums that we received from CMS based on eligibility and dual-eligibility lists that CMS later discovers contained individuals who were not in fact residing in our service areas or eligible for any government-sponsored program or were eligible for a different premium category or a different program. We may have already provided services to these individuals and reimbursement of amounts paid on behalf of services provided to them may be unrecoverable. In addition to recoupment of premiums previously paid, we

also face the risk that CMS could fail to pay us for members for whom we are entitled to payment. Our profitability would be reduced as a result of this failure to receive payment from CMS if we had made related payments to providers and were unable to recoup these payments from them.

Further, our ACOs receive periodic lists of beneficiaries that are assigned to the ACOs. These lists are based on claims experience for certain primary care services. Since CMS adjusts the lists of assigned beneficiaries from time to time, we may expend significant resources on individuals who are not in fact ultimately assigned to our ACOs. This may have a material adverse effect on our ACO business. Further, CMS provides our ACOs with certain historic and current data based on paid claims which is used for a variety of purposes, including, but not limited to, (a) used by CMS to (i) establish the benchmark for an ACO; (ii) calculate beneficiary assignment; and (iii) calculate shared savings; and (b) used by our ACOs to (i) track and trend current medical costs of assigned beneficiaries; (ii) project cost savings, if any, relative to the benchmark established by CMS; and (iii) stratify assigned beneficiaries to identify those with chronic conditions who may benefit from care coordination activities. The failure of CMS to provide timely or accurate data or errors in our processing and evaluation of such data could have a material adverse effect on our ACO business.

If we are unable to develop and maintain satisfactory relationships with the providers of care to our members and ACO beneficiaries, our profitability could be adversely affected and we may be precluded from operating in some markets.

We contract with physicians, hospitals and other providers to deliver health care to our members. Our Medicare Advantage products and ACOs encourage or require our customers to use these contracted providers. In some circumstances, these providers may share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner. Our operations and profitability are significantly dependent upon our ability to not only enter into appropriate cost-effective contracts with hospitals, physicians and other healthcare providers that have convenient locations for our members in our geographic markets, but to maintain good working relationships with such providers. In addition, as the healthcare system rapidly moves to a value-based payment system, the success of each of our Medicare and ACO businesses is and will continue to be highly dependent on achieving high quality scores. This requires significant collaboration with providers to improve customer experience and close gaps in care. If we cannot maintain satisfactory relationships with providers to positively impact quality, our ability to achieve profitability may be negatively impacted.

More specifically, the success of our ACO business is highly dependent on building and maintaining strong relationships with our ACO providers, and if the providers in our ACOs become dissatisfied with our performance or disengaged, it could have a material adverse effect on the results of our ACO business.

In addition, given the rapidly changing environment for healthcare providers, many providers are considering joining larger health systems, including hospitals, which could negatively impact our business. In the long term, our ability to contract successfully with a sufficiently large number of providers in a particular geographic market will affect the relative attractiveness of our managed care products in that market. Any difficulty in contracting with providers in a market could preclude us from renewing or from entering our Medicare contracts in that market. We will be required to establish acceptable provider networks prior to entering new markets or continuing to provide services in existing markets. CMS has indicated that it intends to audit Medicare Advantage plans with respect to network adequacy. There can be no assurance that CMS will not identify areas where we fail to meet applicable network adequacy requirements.

We may be unable to maintain our relationships with our network providers or enter into agreements with providers in new markets on a timely basis or under favorable terms. In any particular market, providers could refuse to contract with us, demand to contract with us, demand higher

payments, or take other actions that could result in higher health care costs for us, less desirable products for members, disruption of benefits to our members, or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physicians, hospitals, independent practice associations and other groups of providers may compete directly with us. Such competition may impact our relationships with those or other providers, adversely affect our products, benefits, or pricing of such products, and may require us to incur additional costs to change our operations, and our results of operations, financial position and cash flows could be adversely affected.

In some situations, we have contracts with individual or groups of primary care physicians for a fixed, per-member-per-month fee under which physicians are paid an amount to provide all required medical services to our members. This type of contract is referred to as a "capitation" contract. The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. In addition, there continues to be significant competition in our markets to employ, contract with or acquire physicians and physician practices which could make it difficult for us to maintain our current relationships. Any of these events could have an adverse effect on the provision of services to our members and our operations, resulting in loss of membership or higher healthcare costs or other adverse effects.

A reduction in the number of members in our Medicare Advantage plans could adversely affect our results of operations.

Over the past several years, we have reduced our Medicare Advantage footprint to focus on markets where we believe we can positively impact the cost and quality of healthcare. These service area reductions have caused our aggregate membership numbers to fall. In the future, we may choose to exit additional markets and may suffer additional membership losses. If we are unable to maintain and grow our membership levels, our business could deteriorate which could have a material adverse effect on our results of operations. A reduction in our membership could also make it more difficult to maintain or lower our administrative expense ratio to appropriate levels. The principal factors that could contribute to the loss of membership are:

- regulatory changes, such as the 45 Day Call Letter issued in February 2017 by CMS and the final rule to be issued in April 2017;
- competition in premium or plan benefits from other health care benefit companies, many of which are larger and have greater resources than we do;
- competition from physicians or other provider groups who may elect to form their own health plans;
- poor Star Ratings relative to our competitors;
- inability to develop and maintain satisfactory relationships with the providers of care to our members;
- increases in our premiums or changes in our benefits provided;

- our exit from a market or the termination of a health plan;
- negative publicity and news coverage relating to our company or the managed health care industry generally;
- insufficient distribution channels in a particular area;
- general economic conditions that induce beneficiaries to cancel their coverage; and
- catastrophic events, such as epidemics, pandemics, natural disasters, acts of terrorism, man-made catastrophes and other unforeseen occurrences.

Our Medicare Advantage membership remains concentrated in certain geographic areas, which exposes us to unfavorable changes in local competition, reimbursement rates, provider pricing power, benefit costs, and other economic conditions.

Our Medicare Advantage membership is significantly concentrated in Texas, New York and Maine. This significant concentration subjects us to greater risk to the extent that adverse conditions develop in one of these areas. Adverse changes in health care or other benefit costs or reimbursement rates payable to providers or increased competition in those geographic areas where we have concentrated membership could result in a disproportionate impact to us as compared to our competitors and material adverse impact on our operating results. Our membership has been and may continue to be affected by adverse and/or uncertain general economic conditions, such as the broad impact of a decline in oil prices and its impact on the Houston market. As a result, we may not be able to achieve, maintain, or grow profits and our revenue and operating results may be materially and adversely affected.

Our business and its growth are subject to risks related to difficulties in the financial markets and general economic conditions.

The financial markets around the world may from time-to-time experience significant disruption, including, among other things, volatility in security prices, diminished liquidity and credit availability, rating downgrades and declining or indeterminate valuations of many investments and declines in real estate values. While these conditions have not historically impaired our ability to access credit markets and finance our operations, largely because our financing has generally come from internal cash generation, there can be no assurance that there will not be a future deterioration in financial markets and confidence in major economies or that any future deterioration in markets or confidence will not impair our ability to access credit markets and finance our operations.

Economic developments affect businesses such as ours in a number of ways, many of which we cannot predict. Among the potential effects could be write-downs in the value of investments we hold and an inability to access credit markets should we require external financing. In addition, it is possible that economic conditions, and resulting budgetary concerns, could prompt the federal, state and local governments to make changes in Medicare programs, which could adversely affect our results of operations. We are unable to predict the likely duration and severity of the future disruptions in financial markets and adverse economic conditions, or the effects these disruptions and conditions could have on us.

We may suffer losses due to fraudulent activity, which could adversely affect our financial condition and results of operation.

Traditional Medicare and Medicare Advantage plans have been subject to fraudulent activity perpetrated by actual and purported beneficiaries and providers, as well as others. In 2009, we incurred significant losses as a result of a fraudulent scheme or a group of similar fraudulent schemes. While we have undertaken efforts to prevent these schemes, there can be no assurance that we will not again

become the target of fraud, or that we will detect fraud prior to incurring losses. The need to expend effort and construct infrastructure to combat fraud requires significant expenditures. These expenditures, and losses arising from any fraud that we suffer, could have a material adverse effect on our financial condition and results of operations.

The occurrence of natural or man-made disasters could adversely affect our financial condition and results of operation.

We are exposed to various risks arising out of natural disasters, such as:

- earthquakes;
- hurricanes;
- floods, tornadoes;
- pandemic health events such as avian influenza; and
- man-made disasters, such as acts of terrorism, political instability and military actions.

For example, a natural or man-made disaster could lead to unexpected changes in persistency rates as policyholders and members who are affected by the disaster may be unable to meet their contractual obligations, such as payment of premiums on our insurance policies. The continued threat of terrorism and ongoing military actions may cause significant volatility in global financial markets, and a natural or man-made disaster could trigger an economic downturn in the areas directly or indirectly affected by the disaster. These consequences could, among other things, result in a decline in business and increased claims from those areas. Disasters also could disrupt communications and financial services and other aspects of public and private infrastructure, which could disrupt our normal business operations.

A natural or man-made disaster also could disrupt the operations of our counterparties or result in increased prices for the products and services they provide to us. In addition, a disaster could adversely affect the value of the assets in our investment portfolio if it affects companies' ability to pay principal or interest on their securities.

If we are unsuccessful in our acquisitions or dispositions it may have an adverse effect on our business, growth plans, financial condition and results of operations.

The rapid changes and complexity of our operations has placed, and will continue to place, significant demands on our management, operations systems, accounting systems, internal control systems and financial resources. As part of our strategy, we have pursued, and may continue to pursue, growth through acquisitions, joint ventures and similar strategic partnerships, to the extent the WellCare Transaction is not consummated. For example, our acquisition of APS Healthcare in 2012 was not successful. From time to time, we may also seek to dispose of assets or businesses that no longer meet our strategic objectives or for other reasons. For example, we sold our APS businesses in 2015 and sold our Traditional Insurance business and TotalCare Medicaid business in 2016. Generally, as part of these sale transactions, the seller is required to indemnify the buyer for certain matters per the contractual terms of the sale agreements. In addition, in connection with the sale of the Traditional Insurance business, all net retained Traditional Insurance business of American Progressive Life and Health Insurance Company of New York (American Progressive) was reinsured on a 100% coinsurance basis to Constitution Life Insurance Company, a Texas domiciled stock corporation which we sold to Nassau Re as part of the transaction. If Constitution Life were to default in its obligations under the reinsurance treaty, American Progressive would ultimately be responsible for the ceded business, which could have a material adverse effect on the Company and its results of operations.

We anticipate that joint ventures with health care providers will be critical to our growth strategies. Joint ventures have certain risks that are different from acquisitions, including, but not limited to, the selection of appropriate partners, challenges with respect to governance of the joint venture, pursuit of growth opportunities acceptable to all the parties, maintaining a positive relationship with our joint venture partner(s), and disruption that may occur should the joint venture terminate for any reason.

These transactions involve numerous risks, some of which we have experienced in the past, such as:

- difficulties in the integration of operations, technologies, products, systems and personnel of the acquired company;
- diversion of financial and management resources from existing operations;
- potential losses from unanticipated litigation, undiscovered or undisclosed liabilities or unanticipated levels of claims relating to either the pre- or post-acquisition periods;
- inability to generate sufficient revenue to offset acquisition costs;
- loss of key customer accounts;
- loss of key provider contracts or renegotiation of existing contracts on less favorable terms; and
- other systems and operational integration risks.

In addition, we generally are required to obtain regulatory approval from one or more governmental agencies when making acquisitions, dispositions or other strategic transactions, which may require a public hearing, regardless of whether we already operate a plan in the state in which the business to be acquired is located. We may be unable to comply with these regulatory requirements for an acquisition, disposition or other strategic transaction in a timely manner, or at all. Even if we identify suitable acquisition targets, we may be unable to complete acquisitions or obtain the necessary financing for acquisitions on terms favorable to us, or at all.

To the extent we complete a strategic transaction; we may be unable to realize the anticipated benefits from it because of operational factors or difficulties in integrating the following or other aspects of acquisitions with our existing businesses:

- additional employees who are not familiar with our operations;
- new provider networks, which may operate on terms different from our existing networks;
- additional members, who may decide to transfer to other healthcare providers or health plans;
- disparate information technology, claims processing and record keeping systems; and
- accounting policies, some of which require a high degree of judgment or complex estimation processes, such as estimates of reserves, IBNR claims, valuation and accounting for goodwill and intangible assets, stock-based compensation and income tax matters.

For all of the above reasons, we may not be able to implement our acquisition strategy successfully, which could materially adversely affect our growth plans and our business, financial condition and results of operations.

Furthermore, in the event of an acquisition or investment, you should be aware that we may issue stock that would dilute stock ownership, incur debt that would restrict our cash flow, assume liabilities, incur large and immediate write-offs, incur unanticipated costs, divert management's attention from our existing business, experience risks associated with entering markets in which we have no or limited prior experience, or lose key employees from the acquired entities or our historical business.

Our reliance upon third party administrators and other outsourcing arrangements may disrupt or adversely affect our operations.

We depend, and may in the future increase our dependence, on independent third parties for significant portions of our operations, including pharmacy benefit administration, data center operations, data network, claims processing, enrollment, premium billing, call centers, voice communication services, data processing and payment and other systems-related support, among others. This dependence makes our operations vulnerable to the third parties' failure to perform adequately under the contract, due to internal or external factors. In the future, this dependence may increase as we may outsource additional areas of our business operations to additional vendors. There can be no assurance that any conversion or transition of business process functions from the Company to a vendor or between vendors will be seamless and, oftentimes, these projects result in significant operational challenges that cause financial difficulties. In addition, if our relationships with our outsourcing partners are significantly disrupted or terminated for any reason or if the financial terms of such outsourcing partners changes materially, we may not be able to find an alternative partner in a timely manner or on acceptable financial terms. As a result, we may not be able to meet the demands of our customers and, in turn, our business, cash flows, financial condition and results of operations may be harmed.

We have outsourced portions of our administrative functions, including, without limitation, the operation of several of our data centers, call centers and claims processing to independent third parties and may from time to time obtain additional services or facilities from other independent third parties. Dependence on third parties for these services and facilities may make our operations vulnerable to their failure to perform as agreed. Incorrect information from these entities could generate inaccurate or incomplete membership and payment reports concerning our Medicare eligibility and enrollment, and claims information used by CMS to determine plan benefit subsidies and risk corridor payments. This could cause us to incur additional expense to utilize additional resources to validate, reconcile and correct the information. We have not been able to independently test and verify some of these third party systems and data. There can be no assurance that future third party data will not disrupt or adversely affect our plans' relationships with our members or our results of operations. A change in service providers, or a move of services from internal operations to a third party, or a move of services from a third party to internal operations, could result in significant operational challenges, a decline in service quality and effectiveness, increased cost or less favorable contract terms, which could adversely affect our operating results. Some of our outsourced services are being performed offshore. CMS requires attestations from plans that utilize the services of offshore vendors as to the vendors' ability to perform delegated functions. Prevailing economic conditions and other circumstances could prevent our offshore vendors' ability to adequately perform as agreed, which would impair our ability to provide the requisite attestations to CMS and could have a material adverse effect on our results of operations and financial condition. Further, significant failure by a third party to perform in accordance with the terms of our contracts or applicable law could subject us to fines or other sanctions or otherwise have a material adverse effect on our business and results of operations.

Our business may suffer if we are not able to hire and retain sufficient qualified personnel or if we lose our key personnel.

Our future success depends partly on the continued contribution of our senior management and other key employees. While we currently have employment agreements with certain key executives, these do not guarantee that the services of these executives will continue to be available to us. In addition, the pending WellCare Transaction generally creates unease with portions of our workforce. The loss of the services of any of our senior management, or other key employees could harm our business. In addition, recruiting and retaining the personnel we require to effectively compete in our

markets may be difficult. If we fail to hire and retain qualified employees, we may not be able to maintain and expand our business.

We may be responsible for the actions of our third party agents, and restrictions on our ability to market would adversely affect our revenue.

In regulatory proceedings and reviews and other litigation, regulators and our members sometimes claim that agents failed to comply with applicable laws, regulations and rules, or acted improperly in other ways, and that we are responsible for the alleged failure. We could be liable for contractual and extra-contractual damages on these claims and other penalties, such as a suspension from marketing and enrolling new members. We cannot assure you that any future claim will not result in material liability in the future. Federal and state regulators increasingly scrutinize the marketing practices of insurers, such as Medicare Advantage plans and their marketing agents, and there is no guarantee that regulators will not continue to scrutinize the practices of our Medicare Advantage plans and our marketing agents, and that such practices will not expose us to liability.

We rely on our marketing and sales efforts for a significant portion of our premium revenue. The federal government and state governments in the states in which we currently operate permit marketing but impose strict requirements and limitations as to the types of marketing activities that we may conduct. If our marketing efforts were to be prohibited or curtailed, our ability to increase or sustain membership would be significantly harmed, which would adversely affect our revenue and results of operations.

We may not be able to compete successfully in our Medicare Advantage business if we cannot recruit and retain insurance agents, which could materially adversely affect our business and ability to compete.

We distribute our Medicare Advantage products principally through employee career agents and independent agents who we recruit and train to market and sell our products. We also engage managing general agents from time to time to recruit agents and develop networks of agents in various states. Strong competition exists for sales agents. We compete with other insurance companies for productive agents, primarily on the basis of our financial position, support services, compensation and product features. It can be difficult to successfully compete for productive agents with larger insurance companies that have higher financial strength ratings than we do. Our business and ability to compete will suffer if we are unable to recruit and retain insurance agents or if we lose the services provided by our managing general agents.

A significant portion of our assets are invested in fixed income securities and other securities that are subject to market fluctuations.

A significant portion of our investment portfolio consists of fixed income securities and other investment securities. Our portfolio can be viewed on our web site, *www.universalamerican.com*, in the "Investors" section. Our reference to the web site in this report is not intended to, and does not, incorporate the information contained in the web site into this report.

The fair value of these assets and the investment income from these assets generally fluctuate depending on general economic and market conditions and these variations have been exacerbated recently. The fair value of our investments in fixed income securities generally increases or decreases in an inverse relationship with fluctuations in interest rates, while net investment income realized by us from future investments in fixed income securities will generally increase or decrease in a direct relationship with fluctuations in interest rates; in addition, these values and prospective income have been adversely affected by general economic conditions. Moreover, actual net investment income or cash flows from investments that carry prepayment risk, such as mortgage-backed and other asset-backed securities, may differ from those anticipated at the time of investment or at various

financial statement dates as a result of interest rate fluctuations, general economic conditions and other factors.

Because our investment securities are classified as available for sale, we reflect changes in the fair value of these securities in our consolidated balance sheets. Therefore, interest rate fluctuations and changes in the values of securities we hold could adversely affect our results of operations and financial condition.

We may not have adequate intellectual property rights in our brand names for our health plans, and we may be unable to adequately enforce these rights.

Our success depends, in part, upon our ability to market our health plans under the brand names that we own or license. We may not have taken enforcement action to prevent infringement of our marks and may not have secured registrations of the other brand names that we use in our business. Unauthorized parties may attempt to copy or otherwise obtain and use our products or technology. Policing unauthorized use of our intellectual property is difficult, and we cannot be certain that the steps we have taken will prevent misappropriation of our intellectual property rights. Other businesses may have prior rights in our brand names or in similar names, which could cause market confusion or limit or prevent our ability to use these marks or prevent others from using similar marks. If we are unable to prevent others from using our brand names, or if others prohibit us from using them, our revenues could be adversely affected. Even if we are able to protect our intellectual property rights in our brands, we could incur significant costs in doing so.

Our results of operations and stockholders' equity could be materially adversely affected if we have an impairment of our intangible assets.

Due to our past acquisitions, goodwill and other intangible assets represent a significant portion of our total assets. As of December 31, 2016, we had goodwill and other intangible assets of approximately $71 million, or approximately 9% of our total assets as of such date.

In accordance with applicable accounting standards, we perform periodic assessments of 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 earnings may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units.

We test goodwill for impairment annually, as of October 1 of the current year, or more frequently if circumstances suggest that impairment may exist. During each quarter, we perform a review of certain key components of our valuation of our reporting units, including the operating performance of the reporting units compared to plan (which is the primary basis for the prospective financial information included in our annual goodwill impairment test), our weighted average cost of capital and our stock price and market capitalization.

We estimate the fair values of our reporting units using discounted cash flows, or other indicators of fair value, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of cash flow (including significant assumptions about operations and target capital requirements), long term growth rates for determining terminal value, and discount rates. Forecasts and long term growth rates used for our reporting units are consistent with, and use inputs from, our internal long term business plan and strategy. During our forecasting process, we assess revenue trends, medical cost trends, operating cost levels and target capital levels. Significant factors affecting these trends include changes in membership, premium yield, medical cost trends, contract renewal expectations and the impact and expectations of regulatory environments.

Although we believe that the financial projections used are reasonable and appropriate at the time made, the use of different assumptions and estimates could materially impact the analysis and resulting conclusions. In addition, due to the long term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of healthcare reforms as discussed in Item 1, "Business—Regulation."

We use a range of discount rates that correspond to a market based weighted average cost of capital. Discount rates are determined for each reporting unit based on the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. The most significant estimates in the discount rate determinations include the risk free rates and equity risk premium. Company specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty in regards to the reporting units' operations could cause these assumptions used in our analysis to change materially in the future. If our assumptions differ from actual, the estimates underlying our goodwill impairment tests could be adversely affected.

Future events that could have a negative impact on the levels of excess fair value over carrying value of our reporting units include, but are not limited to:

- decreases in business growth;
- decreases in forecasted margins;
- the loss of significant contracts;
- decreases in earnings projections;
- increases in the weighted average cost of capital; and
- increases in the amount of required capital for a reporting unit.

Negative changes in one or more of these factors, among others, could result in additional impairment charges.

Our ability to obtain funds from our regulated subsidiaries is restricted and our cash flows and liquidity may be adversely affected which could restrict our ability to pursue new opportunities.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund our obligations, such as payment of principal and interest on our debt obligations. These subsidiaries generally are regulated by state departments of insurance. Our health plan and insurance company subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions they can pay us. These laws and regulations also limit the amount of management fees our subsidiaries may pay to our management subsidiaries and their other affiliates without prior notification to, or in some cases approval of, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends to us, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We are also required by law to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium generated. A significant increase in premium volume will require additional capitalization from our parent company. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends that exceed specified amounts from these subsidiaries, or, in some states, any amount. The pre-approval and notice requirements vary from state to state, and the discretion of the state regulators, if any, in approving or disapproving a dividend is not

always clearly defined. Subsidiaries that declare non-extraordinary dividends must usually provide notice to the regulators in advance of the intended distribution date. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us or to pay management and other fees to affiliates, the funds available to us would be limited, which could impair our ability to implement our business and growth strategy and satisfy our debt obligations, or we could be required to incur additional indebtedness to fund these strategies.

In addition, one or more of these states could increase the minimum statutory capital level from time to time. States have also adopted risk-based capital requirements based on guidelines adopted by the National Association of Insurance Commissioners, which tend to be, although are not necessarily, higher than existing statutory capital requirements. Regardless of whether the states in which we operate maintain or adopt risk-based capital requirements, the state departments of insurance can require our subsidiaries to maintain minimum levels of statutory capital in excess of amounts required under the applicable state laws if they determine that maintaining additional statutory capital is in the best interests of our insureds. Any increases in these requirements could materially increase our reserve requirements. In addition, as we continue to expand our plan offerings in new states or pursue new business opportunities, such as our expansion of Medicare Advantage products and health plans in new markets, we may be required to maintain additional statutory capital reserves. In either case, our available funds could be materially reduced, which could harm our ability to implement our business strategy.

In the event that we are unable to provide sufficient capital to fund our debt obligations, our operations or financial position may be adversely affected.

Our stock price may be volatile and could drop precipitously and unexpectedly.

Our common stock is traded on the NYSE. The prices of publicly traded stocks often fluctuate. The price of our common stock may rise or fall dramatically without any change in our business performance. For example, if our WellCare Transaction is not consummated, our stock price may decline and possibly significantly. Specific issues and developments related to our company or those generally in the health care and insurance industries, the regulatory environment, the capital markets and the general economy may cause this volatility. Our common stock is thinly traded which exposes our stock price to potentially larger fluctuations than other companies and may make it more difficult to buy or sell our stock. The principal events and factors that may cause our stock price and trading volume to fluctuate include:

- failure to consummate the WellCare Transaction;
- changes in the laws and regulations affecting our business;
- the relatively small size of the public float of our common stock and the small volume of trading and the general liquidity in the market for our common stock;
- variations in our operating results;
- changes in the market's expectations about our future operating results;
- changes in financial estimates and recommendations by securities analysts concerning our company or the health care or insurance industries generally;
- operating and stock price performance of other companies that investors may deem comparable;
- news reports relating to trends in our markets;
- acquisitions and financings by us or others in our industry, including news reports or perceptions regarding mergers and acquisitions activity; and

- sales of our common stock by our directors and executive officers or principal shareholders, or the perception that these sales could occur.

Some of our shareholders, directors and executive officers may have interests that conflict with, are different from, or in addition to, the interests of our shareholders generally.

Some of our directors (including their affiliated companies) and executive officers have and may continue to have significant equity ownership in our company, employment, indemnification and severance benefit arrangements, potential rights to other benefits on a change in control and rights to ongoing indemnification and insurance that result in their having interests that may differ from the interests of our shareholders generally. The receipt of compensation or other benefits by our directors or executive officers in connection with any acquisition or disposition may make it more difficult to retain their services after the acquisition or disposition, or require the combined company to expend additional sums to continue to retain their services. In addition, we may enter into transactions, including the sale of stock or assets or similar transactions, with our shareholders, directors or executive officers that may raise a conflict of interest. Further, the current concentration of equity ownership may discourage acquisition transactions. In addition, some of our directors are affiliated with entities that own significant portions of our common stock. Such shareholders may have different investment time horizons than other shareholders and may otherwise have interests that are different than other shareholders.

If we are unable to maintain effective internal controls over financial reporting, investors could lose confidence in the reliability of our financial statements, which could result in a decrease in the price of our common stock.

Because of our status as a public company, we are required to test our financial, internal, and management control systems to meet obligations imposed by the Sarbanes-Oxley Act of 2002. These control systems relate to our corporate governance, corporate control, internal audit, disclosure controls and procedures, and financial reporting and accounting systems. Our disclosure controls and procedures and our internal control over financial reporting may not prevent or detect all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. The design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Further, because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that all control issues and instances of fraud, if any, within our company have been detected. Among these inherent limitations are the realities that judgments in decision-making can be faulty and that breakdowns can occur because of simple error or mistake. The individual acts of some persons or the collusion of two or more people can circumvent controls. The design of any system of controls is based in part on assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions. Projections of any evaluation of controls effectiveness to future periods are subject to risks. Over time, controls may become inadequate because of changes in conditions or deterioration in the degree of compliance with policies or procedures.

If we conclude that we do not have effective internal controls over financial reporting or if our independent auditors are unable to conclude that our internal controls over financial reporting are effective, investors could lose confidence in the reliability of our financial statements, which could result in a decrease in the value of our common stock. Our assessment of our internal controls over financial reporting may also uncover material weaknesses, significant deficiencies or other issues with these controls that could also result in adverse investor reaction. These results may also subject us to adverse regulatory consequences.

Future sales of our common stock in the public market could lower the market price for our common stock and adversely impact the trading price of the notes.

In the future, we may sell additional shares of our common stock to raise capital. In addition, a substantial number of shares of our common stock is reserved for issuance upon the exercise of stock options and upon conversion of the notes. We cannot predict the size of future issuances or the effect, if any, that they may have on the market price for our common stock. In addition, certain of our shareholders hold meaningful amounts of our common stock and such shareholders may sell their shares. Future sales of our common stock may depress the market price of our common stock. The issuance and/or sale of substantial amounts of our common stock, or the perception that such issuances and/or sales may occur, could adversely affect the trading price of the notes and the market price of our common stock and impair our ability to raise capital through the sale of additional equity securities.

Risks Related to our Convertible Senior Notes:

The notes are not protected by restrictive covenants.

Unlike an indenture for high yield notes or a customary credit agreement, the indenture governing the notes does not contain any financial or operating covenants or restrictions on the payments of dividends, the incurrence of indebtedness or the issuance or repurchase of securities by us or any of our subsidiaries. In general, the indenture contains limited covenants or other provisions to afford protection to holders of the notes in the event of a fundamental change or other corporate transaction involving us.

The notes are effectively subordinated to our secured debt and any liabilities of our subsidiaries.

The notes rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the notes; equal in right of payment to any of our liabilities that are not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries. In the event of our bankruptcy, liquidation, reorganization or other winding up, our assets that secure debt ranking senior in right of payment to the notes will be available to pay obligations on the notes only after the secured debt has been repaid in full from these assets. There may not be sufficient assets remaining to pay amounts due on any or all of the notes then outstanding. The indenture governing the notes does not prohibit us from incurring additional senior debt or secured debt, nor does it prohibit any of our subsidiaries from incurring additional liabilities.

The notes are our obligations only and our operations are conducted through, and substantially all of our consolidated assets are held by, our subsidiaries.

The notes are our obligations exclusively and are not guaranteed by any of our operating subsidiaries. A substantial portion of our consolidated assets is held by our subsidiaries. Accordingly, our ability to service our debt, including the notes, depends on the results of operations of our subsidiaries and upon the ability of such subsidiaries to provide us with cash, whether in the form of dividends, loans or otherwise, to pay amounts due on our obligations, including the notes. Our subsidiaries are separate and distinct legal entities and have no obligation, contingent or otherwise, to make payments on the notes or to make any funds available for that purpose. In addition, dividends, loans or other distributions to us from such subsidiaries may be subject to contractual, statutory and other restrictions and are subject to other business considerations.

Servicing our debt requires a significant amount of cash, and we may not have sufficient cash flow from our business to pay our substantial debt.

Our ability to make scheduled payments of the principal of, to pay interest on or to refinance our indebtedness, including the notes, depends on our future performance, which is subject to economic, financial, competitive and other factors beyond our control. Our business may not continue to generate cash flow from operations in the future sufficient to service our debt and make necessary capital expenditures. If we are unable to generate such cash flow, we may be required to adopt one or more alternatives, such as selling assets, restructuring debt or obtaining additional equity capital on terms that may be onerous or highly dilutive. Our ability to refinance our indebtedness will depend on the capital markets and our financial condition at such time. We may not be able to engage in any of these activities or engage in these activities on desirable terms, which could result in a default on our debt obligations.

Despite our current debt levels, we may still incur substantially more debt.

Despite our current consolidated debt levels, we and our subsidiaries may be able to incur substantial additional debt in the future, some of which may be secured debt, subject to the restrictions contained in our debt instruments. We will not be restricted under the terms of the indenture governing the notes from incurring additional debt, securing existing or future debt, recapitalizing our debt or taking a number of other actions that are not limited by the terms of the indenture governing the notes that could have the effect of diminishing our ability to make payments on the notes when due.

We may not have the ability to raise the funds necessary to settle conversions of the notes or to repurchase the notes upon a fundamental change, and our future debt may contain limitations on our ability to pay cash upon conversion or repurchase of the notes.

Holders of the notes will have the right to require us to repurchase their notes upon the occurrence of a fundamental change at a fundamental change repurchase price equal to 100% of the principal amount of the notes to be repurchased, plus accrued and unpaid interest, if any. In addition, upon conversion of the notes, unless we elect to deliver solely shares of our common stock to settle such conversion (other than paying cash in lieu of delivering any fractional share), we will be required to make cash payments in respect of the notes being converted. However, we may not have enough available cash or be able to obtain financing at the time we are required to make repurchases of notes surrendered therefor or notes being converted. In addition, our ability to repurchase the notes or to pay cash upon conversions of the notes may be limited by law, by regulatory authority or by agreements governing our future indebtedness. Our failure to repurchase notes at a time when the repurchase is required by the indenture or to pay any cash payable on future conversions of the notes as required by the indenture would constitute a default under the indenture. A default under the indenture or the fundamental change itself could also lead to a default under agreements governing our future indebtedness. If the repayment of our then-existing indebtedness were to be accelerated after any applicable notice or grace periods, we may not have sufficient funds to repay the indebtedness and repurchase the notes or make cash payments upon conversions thereof.

The accounting method for convertible debt securities that may be settled in cash, such as the notes, could have a material effect on our reported financial results.

Accounting for convertible debt securities under GAAP is governed by Accounting Standards Codification 470-20, Debt with Conversion and Other Options, which we refer to as ASC 470-20. Under ASC 470-20, an entity must separately account for the liability and equity components of the convertible debt instruments (such as the notes) that may be settled entirely or partially in cash upon conversion in a manner that reflects the issuer's economic interest cost. The effect of ASC 470-20 on the accounting for the notes is that the equity component is required to be included in the additional

paid-in capital section of stockholders' equity on our consolidated balance sheet, and the value of the equity component would be treated as original issue discount for purposes of accounting for the debt component of the notes. As a result, we will be required to record a greater amount of non-cash interest expense in current periods presented as a result of the amortization of the discounted carrying value of the notes to their face amount over the term of the notes. We may report lower net income in our financial results because ASC 470-20 will require interest to include both the current period's amortization of the debt discount and the instrument's coupon interest, which could adversely affect our reported or future financial results, the trading price of our common stock and the trading price of the notes.

In addition, under certain circumstances, convertible debt instruments (such as the notes) that may be settled entirely or partly in cash are currently accounted for utilizing the treasury stock method, the effect of which is that the shares issuable upon conversion of the notes are not included in the calculation of diluted earnings per share except to the extent that the conversion value of the notes exceeds their principal amount. Under the treasury stock method, for diluted earnings per share purposes, the transaction is accounted for as if the number of shares of common stock that would be necessary to settle such excess, if we elected to settle such excess in shares, are issued. We cannot be sure that the accounting standards in the future will continue to permit the use of the treasury stock method. If we are unable to use the treasury stock method in accounting for the shares issuable upon conversion of the notes, then our diluted earnings per share could be adversely affected.

ITEM 1B—UNRESOLVED STAFF COMMENTS

There are no unresolved comments from the Staff of the Securities and Exchange Commission regarding the registrant's periodic or current reports under the Act.

ITEM 2—PROPERTIES

Our corporate headquarters are located in White Plains, New York. We also have offices in Houston, Texas; and Syracuse, New York. In addition, we maintain other smaller offices to support our businesses. Management considers its office facilities suitable and adequate for the current level of operations. Additional information regarding our lease obligations is included in Note 22—Commitments and Contingencies in the Notes to Consolidated Financial Statements included in this Annual Report on Form 10-K.

ITEM 3—LEGAL PROCEEDINGS

In addition to the matters discussed below, we are or may also be subject to a variety of legal proceedings, alternative dispute resolution proceedings, governmental investigations, including SEC investigations, audits, claims and litigation, including claims under the False Claims Act and claims for benefits under insurance policies and claims by members, providers, customers, employees, regulators and other third parties. In some cases, plaintiffs may seek punitive damages. It is not possible to accurately predict the outcome or estimate the resulting penalty, fine or other remedy that may result from any current or future legal proceeding, investigation, audit, claim or litigation. Nevertheless, the range of outcomes and losses could be significant and could have a material adverse effect on our consolidated financial statements.

Governmental Regulation

Laws and regulations governing Medicare and other state and federal healthcare and insurance programs are complex and subject to significant interpretation. As part of the Affordable Care Act, known as ACA, CMS, state regulatory agencies and other regulatory agencies have been exercising increased oversight and regulatory authority over our Medicare and other businesses. Compliance with

such laws and regulations is subject to CMS audit, other governmental review and investigation, including SEC investigations and significant and complex interpretation. CMS audits our Medicare Advantage plans with regularity to ensure we are in compliance with applicable laws, rules, regulations and CMS instructions. Our Medicare Advantage plans will likely be subject to audit in 2017. There can be no assurance that we will be found to be in compliance with all such laws, rules and regulations in connection with these audits, reviews and investigations, and at times we have been found to be out of compliance. Failure to be in compliance can subject us to significant regulatory action including significant fines, penalties, cancellation of contracts with governmental agencies or operating restrictions on our business, including, without limitation, suspension of our ability to market to and enroll new members in our Medicare plans, termination of our contracts with CMS, exclusion from Medicare and other state and federal healthcare programs and inability to expand into new markets or add new products within existing markets.

Certain of our subsidiaries provide products and services to various government agencies. As a government contractor, we are subject to the terms of the contracts we have with those agencies and applicable laws governing government contracts. As such, we may be subject to False Claim Act litigation (also known as qui tam litigation) brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government.

ITEM 4—MINE SAFETY DISCLOSURES

N/A

PART II

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

Market Information

The following table sets forth the high and low closing sales prices for Universal American common stock on the NYSE National Market, as reported by the NYSE for the periods indicated. Prices have been adjusted to reflect the $0.75 dividend paid in October 2015.

	Common Stock		Cash Dividends Declared
	High	Low	
2016			
Fourth Quarter	$ 10.04	$ 7.37	$ —
Third Quarter	$ 7.95	$ 6.84	$ —
Second Quarter	$ 8.45	$ 7.05	$ —
First Quarter	$ 7.26	$ 5.70	$ —
2015			
Fourth Quarter	$ 7.65	$ 5.93	$ 0.75
Third Quarter	$ 9.38	$ 6.00	$ —
Second Quarter	$ 10.22	$ 8.42	$ —
First Quarter	$ 9.93	$ 8.03	$ —

The closing sale price of our common stock on February 24, 2017, as reported by the NYSE, was $9.95 per share.

Shareholders

As of the close of business on February 24, 2017, there were approximately 800 registered holders of record of our voting common stock and one holder of record for our nonvoting common stock.

Dividends

On October 26, 2015, we paid a special cash dividend of $0.75 per share, to shareholders of record on October 19, 2015.

Issuer Purchases of Equity Securities

On June 27, 2016, in connection with the issuance of our convertible notes, we repurchased all 11,011,515 shares of our common stock held by certain affiliates of Perry Capital and 7,098,775 shares of our common stock held by certain affiliates of Welsh, Carson, Anderson & Stowe at a purchase price of $6.80 per share. In connection with the convertible notes issuance, we also repurchased 2,082,800 shares of our common stock at an average price of $7.26 in privately negotiated transactions.

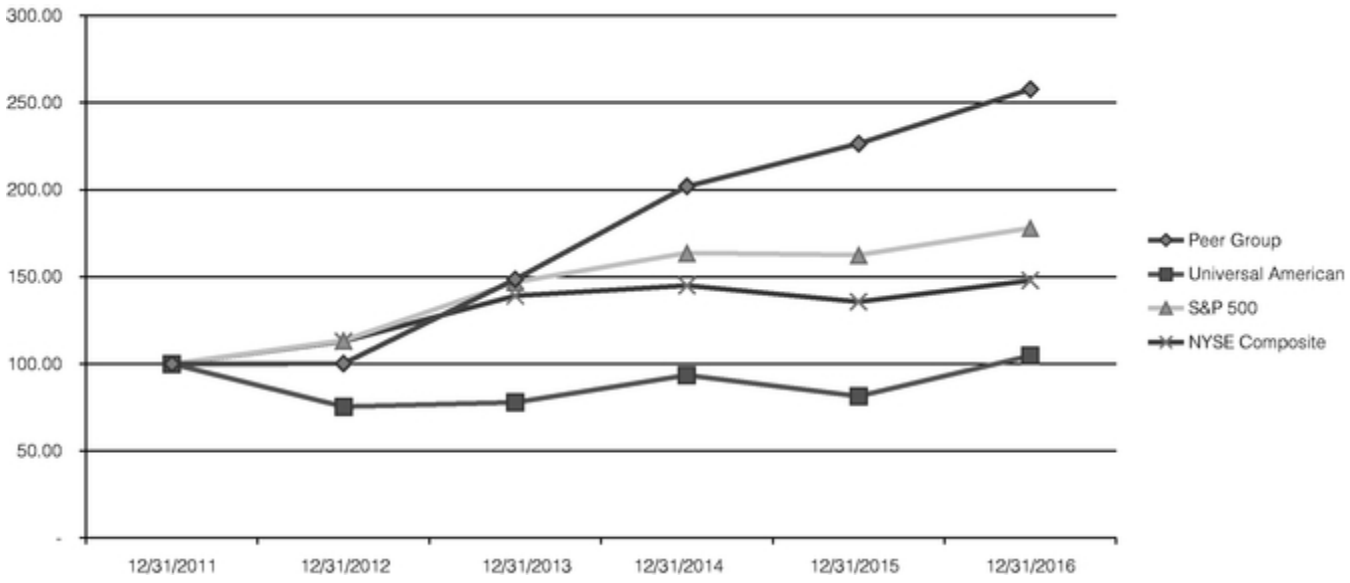
On September 9, 2016, in connection with settlement of our litigation arising out of the APS Healthcare acquisition, we acquired all of the 6,272,104 shares of common stock held by the funds affiliated with GTCR and other individuals. See Note 22 Commitments and Contingencies for additional information regarding this settlement.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on our common stock with the cumulative total return of the NYSE Composite Index, and the Dow Jones US Select Health Care

Providers Index, to represent our peer group. The graph assumes an investment of $100 in each of our common stock, the NYSE Composite group, and the peer group on December 31, 2011. The graph assumes that the value of the investment in our common stock and in the above referenced indices was $100 at December 31, 2011 and that all dividends were reinvested. The price of our common stock on December 31, 2011, on which the graph is based, was $12.71. The shareholder return shown on the following graph is not necessarily indicative of future performance.

Comparison of Cumulative Total Return Among
Universal American Corp. Common Stock,
New York Stock Exchange Composite Index, S&P 500 Index and
Peer Group
December 31, 2011 through December 31, 2016



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

Recent Sales of Unregistered Securities

None.

Securities Authorized for Issuance under Equity Compensation Plans

The information regarding securities authorized for issuance under our equity compensation plans is disclosed in Item 12 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters."

ITEM 6—SELECTED FINANCIAL DATA

The table below provides selected financial data and other operating information as of and for the five years ended December 31, 2016. We derived the selected financial data presented below from our audited financial statements. In 2016, we sold our Medicaid business, which is reported in discontinued operations. In addition, the Traditional Insurance business, which was reported as held for sale at December 31, 2015 and our APS Healthcare businesses, which were sold in 2015 were reported as discontinued operations as of December 31, 2015. Our Consolidated Financial Statements and the selected financial data presented below have been restated for all periods to reflect these businesses as discontinued operations. See Note 21—Discontinued Operations for additional information on the

above transactions. We have prepared the following data, other than statutory data, in conformity with U.S. generally accepted accounting principles, known as GAAP. You should read this selected financial data together with our Consolidated Financial Statements and the Notes to Consolidated Financial Statements as well as the discussion under the caption "Management's Discussion and Analysis of Financial Condition and Results of Operations."

	For the Year Ended December 31,				
	2016	2015	2014	2013	2012
	(in thousands, except per share data)				
Income Statement Data:					
Net premiums	$ 1,366,716	$ 1,245,971	$ 1,394,736	$ 1,617,176	$ 1,619,336
Net investment income	8,594	11,957	19,588	18,997	23,453
Fee and other income	2,907	4,524	3,434	512	3,948
Net realized gains (losses)	1,429	38,954	(649)	13,806	14,315
Total revenues	**1,379,646**	**1,301,406**	**1,417,109**	**1,650,491**	**1,661,052**
Total benefits, claims and expenses	1,381,590	1,291,691	1,432,031	1,633,038	1,594,261
(Loss) income from continuing operations before equity in losses of unconsolidated subsidiaries	(1,944)	9,715	(14,922)	17,453	66,791
Equity in income (losses) of unconsolidated subsidiaries	4,998	(9,626)	(17,793)	(33,602)	(10,222)
Income (loss) from continuing operations before taxes	**3,054**	**89**	**(32,715)**	**(16,149)**	**56,569**
Provision for (benefit from) income taxes	9,344	3,785	(6,107)	(4,597)	17,214
(Loss) income from continuing operations	**(6,290)**	**(3,696)**	**(26,608)**	**(11,552)**	**39,355**
Discontinued operations:					
Income (loss) from discontinued operations before income taxes	67,663	(188,371)	(1,210)	(187,087)	21,065
Provision for (benefit					

from) income taxes	5,997	(28,098)	1,649	(6,313)	7,387
Income (loss) from discontinued operations	61,666	(160,273)	(2,859)	(180,774)	13,678
Net income (loss)	**$ 55,376**	**$ (163,969)**	**$ (29,467)**	**$ (192,326)**	**$ 53,033**
Income (loss) per common share:					
Basic:					
Continuing operations	$ (0.09)	$ (0.04)	$ (0.32)	$ (0.13)	$ 0.46
Discontinued operations	0.87	(1.95)	(0.03)	(2.07)	0.15
Net income (loss)	$ 0.78	$ (1.99)	$ (0.35)	$ (2.20)	$ 0.61
Diluted:					
Continuing operations	$ (0.09)	$ (0.04)	$ (0.32)	$ (0.13)	$ 0.45
Discontinued operations	0.87	(1.95)	(0.03)	(2.07)	0.16
Net income (loss)	$ 0.78	$ (1.99)	$ (0.35)	$ (2.20)	$ 0.61

	As of December 31,				
	2016	2015	2014	2013	2012
	(in thousands, except per share data)				
Balance Sheet Data:					
Total cash and investments	$ 355,956	$ 362,056	$ 444,716	$ 470,404	$ 564,076
Total assets	785,583	1,730,862	2,100,501	2,171,097	2,559,766
Policyholder related liabilities	82,898	86,976	94,836	120,269	115,611
Stockholders' equity	269,413	382,395	614,465	664,899	1,012,497
Book value per share:					
Basic	$ 4.57	$ 4.52	$ 7.34	$ 7.49	$ 11.47
Cash dividends per common share	$ —	$ 0.75	$ —	$ 1.60	$ 1.00
Data Reported to Regulators (1):					
Statutory capital and surplus	$ 192,454	$ 282,469	$ 345,422	$ 369,850	$ 564,380
Asset valuation reserve	850	3,597	4,510	3,911	2,967
Adjusted capital and surplus	$ 193,304	$ 286,066	$ 349,932	$ 373,761	$ 567,347

(1) 2015 and prior periods include capital and surplus for Constitution Life Insurance Company (Constitution) and The Pyramid Life Insurance Company (Pyramid) which was transferred to Nassau Reinsurance Group Holdings, L.P. in connection with the August 3, 2016 sale of our Traditional Insurance business and Today's Options of New York which was transferred to Molina Healthcare, Inc. (Molina) in connection with the August 1, 2016 sale of our Medicaid business. 2014 and prior also include capital and surplus of Marquette National Life Insurance Company (Marquette) and American Pioneer Life Insurance Company which were merged into Constitution during 2015. In addition, 2012 includes capital and surplus of Union Bankers Insurance Company which was merged into Constitution during 2013. At December 31, 2015, Constitution and Pyramid had combined capital and surplus of $82.7 million and combined asset valuation reserve of $1.9 million.

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

Introduction

The following discussion and analysis presents a review of our financial condition as of December 31, 2016 and our results of operations for the years ended December 31, 2016, 2015 and 2014. As used in this report, except as otherwise indicated, references to the "Company," "Universal American," "we," "our," and "us" are to Universal American Corp., a Delaware corporation and its subsidiaries.

You should read the following analysis of our consolidated results of operations and financial condition in conjunction with the consolidated financial statements and related consolidated footnotes included in this Annual Report on Form 10-K. The following discussion contains forward-looking statements that involve risks, uncertainties and assumptions that could cause our actual results to differ materially from management's expectations. Factors that could cause such differences include those set forth under Part I, Item 1A—*Risk Factors.*

Overview

Universal American, through our family of healthcare companies, provides health benefits to people covered by Medicare. Our core strength is our ability to partner with providers, especially primary care physicians to improve health outcomes while reducing cost in the Medicare population. We currently are focused on two main businesses:

- **Medicare Advantage:** We currently serve the growing Medicare population by providing Medicare Advantage products to approximately 119,500 members. Approximately 31% of the Medicare population in the United States is currently enrolled in Medicare Advantage plans; a type of Medicare health plan offered by private companies that contract with the federal government to provide enrollees with health insurance. Our current focus is to grow our Medicare Advantage business in Texas (especially Houston/Beaumont), upstate New York and Maine, regions in which we have meaningful market positions.

- **Medicare Accountable Care Organizations:** We believe there is a significant opportunity to address the high cost and lack of coordination of health care for the majority of the Medicare fee-for-service population and have joined with provider groups to operate Accountable Care Organizations, or ACOs, that participate in the Medicare Shared Saving Program, known as the MSSP. We currently operate sixteen MSSP ACOs and two Next Generation ACOs, including approximately 5,200 participating providers with approximately 221,800 assigned Medicare fee-for-service beneficiaries.

Pending Sale to WellCare

On November 17, 2016, we entered into a definitive agreement with WellCare Health Plans, Inc. ("WellCare") under which WellCare will acquire Universal American in an all cash transaction valued at $10.00 per share of common stock. We refer to this transaction throughout this Form 10-K as the "Sale Transaction". On December 30, 2016, the request for early termination of the waiting period under the Hart-Scott-Rodino Antitrust Improvements Act (HSR Act) was approved. In addition, on February 16, 2017, our stockholders approved the Sale Transaction. WellCare and the Company are pursuing the remaining regulatory approvals from regulatory agencies in Texas and New York. The Sale Transaction is expected to close in the second quarter of 2017, subject to the receipt of regulatory approvals and other customary closing conditions.

Healthy Collaboration® Strategy

We have developed a successful primary care physician alignment strategy that we have branded as The Healthy Collaboration®. We work in collaboration with healthcare providers, especially primary care physicians, to help them assume and manage risk, in order to achieve measurably better quality and lower cost. Primary care is among the least expensive part of the overall care continuum. We believe that if given the right tools and incentives, primary care physicians can have significant leverage in improving the cost and quality of health care. Below are the key elements of the strategy:

- We align incentives through gain sharing arrangements so that providers are incented to assist members to achieve healthy outcomes;
- We provide actionable data and analytics to providers and employ enabling technology to ensure that the right care is delivered at the right time in the right setting; and
- We engage the people we serve to help them make informed choices about their healthcare.

Emerging Opportunities in Healthcare

Senior Market Opportunity

We believe that attractive growth opportunities exist in providing health insurance to the growing senior market. At present, approximately 57 million Americans are eligible for Medicare, the Federal program that offers basic hospital and medical insurance to people over 65 years old and some disabled people under the age of 65. According to the Pew Research Center, more than 3.5 million Americans turn 65 in the United States each year, and this number is expected to grow as the so-called baby boomers continue to turn 65 and continue for nearly 20 years. In addition, many large employers that traditionally provided medical and prescription drug coverage to their retirees have begun to curtail these benefits. Medicare Advantage continues to grow its share of the overall Medicare market and we believe is likely to continue to gain positive acceptance with consumers.

Over the past several years, we made a strategic decision to offer Medicare Advantage plans only in markets where we believe we can positively impact the cost and quality of healthcare through collaboration with providers. Accordingly, we now offer plans in only three states (Texas, New York and Maine). In the Houston/Beaumont region, we currently maintain the leading market position with strong brand awareness and committed and aligned physician groups with whom we share risk. In upstate New York, we are in the process of converting this historically fee-for-service market into a more value-based system by introducing pay for performance to the primary care physicians in the region.

For 2017, the Company earned a 4.5-Star rating for its flagship TexanPlus® plan in Houston/Beaumont, which accounts for 57% of our December 31, 2016 membership, and maintained a 4-Star rating for our Today's Options PPO plan in New York and Maine. Collectively, over 70% of our members are in Plans with a Star rating of 4.0 or greater. Plans that achieve a 4-Star rating or better are entitled to additional bonus payments and higher rebate percentages from CMS which enables the plans to enhance their product offering to members and prospective members through reduced premiums, reduced member cost sharing amounts, and/or additional benefits.

Medicare Advantage

Medicare Advantage—Texas: Universal American's largest Medicare Advantage market is Texas, primarily the Houston/Beaumont region and North Texas. We market our products using the TexanPlus® brand. The products provided in our Texas markets are HMO plans, including a special needs plan for dual eligibles (dSNP), which was introduced in 2016 and currently has nominal membership. Enrollment in this market is generally supported by employed career agents.

- Our HMO plans are offered under contracts with CMS and provide all basic Medicare covered benefits with reduced member cost-sharing as well as additional supplemental benefits, including a defined prescription drug benefit. We built this coordinated care product around contracted networks of providers who, in cooperation with the health plan, coordinate an active care management program. In addition to a monthly payment per member from CMS, the plan may collect a monthly premium from its members enrolled in specified products. For 2017, these HMO plans are offered with a $0 member premium, except for the dSNP, which offers a subsidized premium.

- In connection with the HMOs, we operate separate Medicare Advantage Management Service Organizations that manage that business and affiliated Independent Physician Associations or IPAs through gain sharing arrangements. We participate in the net results derived from these affiliated IPAs.

Medicare Advantage—Northeast: Universal American's second largest market is upstate New York, primarily the ten counties that are considered part of the Syracuse market. Universal American markets its Medicare Advantage products using the Todays Options® brand. Enrollment in this market is generally supported by independent agents.

The products provided in our Northeast market include PPO and Network PFFS.

- Our PPO plans are provided under the brand Today's Options® PPO. They are offered under contracts with CMS and provide all basic Medicare covered benefits with reduced member cost-sharing as well as additional supplemental benefits, including a defined prescription drug benefit. This coordinated care product is built around contracted networks of providers who, in cooperation with the health plan, coordinate an active care management program. In addition to a monthly payment per member from CMS, the plan may collect a monthly premium from its members enrolled in specified products.

- Our Network PFFS plans, which are provided under the brand Today's Options® are offered under contracts with CMS and provide enhanced health care benefits compared to Medicare fee-for-service, subject to cost sharing and other limitations. Even though these plans allow the members more flexibility in the delivery of their health care services than other Medicare Advantage plans, we actively coordinate care for these members in a similar manner to our PPO and HMO plans. Some of these products include a defined prescription drug benefit. In addition to a fixed monthly payment per member from CMS, individuals in these plans may be required to pay a monthly premium in selected counties or for selected enhanced products.

Accountable Care Organizations

The Patient Protection and Affordable Care Act and The Healthcare and Education Reconciliation Act of 2010, which we collectively refer to as the ACA established Medicare Shared Savings ACOs as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service, or FFS, program, which covers the majority of the Medicare-eligible population. The MSSP covers nearly eight million FFS beneficiaries comprising approximately 430 ACOs. CMS established the MSSP to facilitate coordination and cooperation among providers to improve the quality of care for FFS beneficiaries and reduce unnecessary costs. The MSSP is designed to improve beneficiary outcomes and increase value of care by:

- promoting accountability for the care of Medicare FFS beneficiaries;

- fostering better coordination of care for items and services provided under Medicare FFS; and

- encouraging investment in infrastructure and redesigned care processes.

The MSSP will reward ACOs that lower their health care costs while surpassing a minimum savings rate and meeting quality of care performance standards. Cost savings below the benchmark provided by CMS will be shared at least 50% with the ACOs. The minimum savings rate set by CMS varies depending on the number of beneficiaries assigned to the ACO, starting at 3.9% for ACOs with assigned beneficiaries totaling 5,000 and grading to 2.0% for ACOs with assigned beneficiaries totaling 60,000 or more.

In June 2015, the MSSP rules were revised in several important ways that we believe demonstrates an ongoing commitment by CMS to maintain participation in the MSSP. For example, Medicare ACOs now have more options under the MSSP, such as:

- **MSSP Track 1:** One-sided risk (upside only); up to 50% shared savings; retrospective attribution
- **MSSP Track 2:** Two-sided risk; up to 60% shared savings; retrospective attribution
- **MSSP Track 3:** Two-sided risk; up to 75% shared savings; prospective attribution

Additionally, the CMS Center for Medicare and Medicaid Innovation, or CMMI, launched the Next Generation ACO Model, a new value-based payment model that encourages providers to assume greater risk and reward in coordinating the healthcare of Medicare fee-for-service beneficiaries. The Next Generation ACO Model provides ACOs with additional tools not found in the MSSP but used in the Medicare Advantage program to improve quality and lower cost, including preferred networks, negotiated discounts and beneficiary incentives. The Next Generation ACO Model offers two risk arrangements with prospectively assigned beneficiaries under which a Next Generation ACO can share up to 80% or 100% of savings (losses) generated in each performance year depending on the financial arrangement selected by the ACO.

Universal American currently sponsors sixteen MSSP ACOs in ten States and two Next Generation ACOs which include approximately 5,200 participating providers and approximately 221,800 Medicare FFS beneficiaries covering more than $2.4 billion of medical spend. Certain of our ACOs overlap a portion of our Medicare Advantage footprint (Houston, Dallas and New York) which capitalizes on our existing relationship with providers. The other ACOs have no overlap with existing operations, offering an opportunity for expansion into other products and services.

In 2017, three of our MSSP ACOs elected Track 2 with the balance of MSSP ACOs remaining on Track 1. In addition, we formed a new ACO comprised of many of our providers who participated in our Maryland and Virginia ACOs which was selected by CMS to participate in the Next Generation ACO model effective January 1, 2017. Our other Next Generation ACO operates in Houston, Texas.

We provide our ACOs with care coordination, analytics and reporting, technology and other administrative capabilities to enable participating providers to deliver better care and lower healthcare costs for their Medicare FFS beneficiaries. We employ local market staff (operations and clinical) to drive physician and their staff engagement and care coordination improvements. Over the past few years, we have reduced the number of our active ACOs based on a variety of factors, including the level of engagement by the physicians in the ACO and the likelihood of the ACO achieving shared savings. We may make further reductions in the future.

On July 29, 2016, CMS informed us that our MSSP ACOs generated $97 million in gross savings for program year 2015. This compares to $80 million in gross savings for program year 2014, which we reported in the second quarter of 2015. 10 of our ACO's qualified for shared savings payments, compared to 9 in program year 2014, and received payments of $39.8 million, compared to $26.9 million in program year 2014. Our share of these payments for 2016, after payments to our physician partners of $11.3 million, is $28.5 million, compared to $20.9 million in 2015, and is reflected in equity in earnings (losses) of unconsolidated subsidiaries in our consolidated statements of operations. We received these payments during the third quarter of 2016.

On July 30, 2015, CMS informed us that our 23 MSSP ACOs which were active in 2014, generated $80 million in gross savings for program year 2014. This compares to $66 million in gross savings for 2012/2013, the first program period of the MSSP, which comprised up to 21 months and which we reported in the third quarter of 2014. For these 23 ACOs, the program year 2014 results showed that:

- 9 ACOs, serving more than 105,000 Medicare beneficiaries, including our flagship ACO in Houston, qualified for shared savings totaling $26.9 million. Our share of these payments, recorded in the second quarter of 2015, after payments to our physician partners of $6.0 million, increased to $20.9 million, which is reflected in equity in losses of unconsolidated subsidiaries in our consolidated statements of operations. We received these payments during October 2015;

- 8 additional ACOs achieved savings but did not exceed the Minimum Savings Rate, known as MSR. Of those eight, four missed the MSR by less than 1%; and

- Quality scores improved for all ACOs, which indicates improved healthcare management particularly for our chronically ill beneficiaries.

During September 2014, we received notice that the ACOs generated $66 million in total program savings for CMS, as part of the MSSP for the first performance year of the MSSP (2012 and 2013). Of our 30 ACOs with start dates in 2012 and 2013, the results showed that:

- 3 ACOs, serving more than 56,000 Medicare beneficiaries and including our largest ACO in Houston, generated savings in excess of their Minimum Savings Rate and therefore, qualified to share those savings with CMS;

- 11 ACOs, serving more than 120,000 Medicare beneficiaries, generated savings but fell below their Minimum Savings Rate required to share savings with CMS;

- 8 ACOs were within 2 percent of their benchmark;

- 8 ACOs were 2 percent or more above their benchmark; and

- All ACOs met CMS's quality reporting standards.

The three ACOs qualifying for savings received payments of $20.4 million, part to be shared between the physicians of those ACOs and us and part to be used by us to reimburse a portion of the costs that we had incurred. Our share of these savings, including expense recovery, amounted to $13.4 million, which is reflected in equity in losses of unconsolidated subsidiaries in our consolidated statements of operations. We received these payments in October 2014. We did not recognize any shared savings revenue in 2013.

The MSSP is relatively new and therefore has limited historical experience. This impacts our ability to accurately accumulate and interpret the data available for calculating the ACOs' shared savings. Therefore, during 2016, 2015 and 2014, we recognized our portion of ACO shared savings revenue when notified by CMS. Such notification lags the Program Year to which the revenue relates by six to nine months. Revenue from the initial 2012/2013 Program Year, which ended on December 31, 2013, was recorded in the quarter ended September 30, 2014 and revenue for the 2014 Program Year, which ended on December 31, 2014, was recorded in the quarter ended June 30, 2015. Revenue for the 2015 Program Year, which ended on December 31, 2015, was recorded in the quarter ended June 30, 2016. Similarly, we were not able to recognize revenue for the year ended December 31, 2016 in the 2016 financial statements. We expect that revenue, if any, for the program year ended December 31, 2016 will be reported in 2017 when the MSSP revenue is either known or estimable with reasonable certainty. Based on the ACO operating agreements, we bear all costs of the ACO operations until revenue is recognized. At that point, we share in up to 100% of the revenue to recover our costs incurred. Any remaining revenue is generally shared equally with our ACO provider partners.

During 2016, we operated one ACO under the new Next Generation ACO Model. This Next Generation ACO Model has different provisions than the MSSP ACOs, and receives different beneficiary information from CMS during the year. During 2016, we were able to use this beneficiary information to estimate Program Year 2016 revenue for this Next Generation ACO, but determined, based on the information available, that this ACO would not generate any shared savings. Based on our analysis, we accrued a $1.7 million estimated loss for 2016.

Healthcare Reform

The ACA was signed into law in March 2010 and legislated broad based changes to the U.S. health care system which continue to have a material impact on our business. There is considerable discussion within the new Presidential administration and Congress about repealing and replacing the ACA. At this time, it is uncertain whether, when, and what changes will be made to the ACA, and what impact such changes could have on our business. However, any changes to the ACA, including through any repeal and replacement to the ACA, could have a material adverse effect on our business, financial position and results of operations.

The provisions of these new laws include the following key points, which are discussed further below:

- reduced Medicare Advantage reimbursement rates, beginning in 2012;
- implementation of a quality bonus for Star ratings, beginning in 2012;
- accountable care organizations, beginning in 2012;
- stipulated minimum medical loss ratios (MLR), beginning in 2014;
- non-deductible health insurance industry fee, beginning in 2014;
- coding intensity adjustments, with mandatory minimums, beginning in 2014; and
- limitation on the federal tax deductibility of compensation earned by individuals for certain types of companies, beginning in 2013.

Reduced Medicare Advantage reimbursement rates—The ACA made several changes to Medicare Advantage. Beginning in 2012, the Medicare Advantage "benchmark" rates began the transition to target Medicare fee-for-service cost benchmarks of 95%, 100%, 107.5% or 115% of the calculated Medicare fee-for-service costs. The transition period is 2, 4 or 6 years depending upon the applicable county and 2017 will be the final transition year. The counties are divided into quartiles based on each county's fee-for-service Medicare costs. We estimate that approximately 61%, 32% and 6%, respectively, of our January 1, 2017 membership resides in counties where the Medicare Advantage benchmark rate will equal 95%, 115%, and 107.5%, respectively, of the calculated Medicare fee-for-service costs.

Medicare Advantage payment benchmarks have been cut over the last several years, with additional funding reductions to be phased in as noted above. On February 1 2017, CMS issued its 2018 Advance Notice and Draft Call Letter (the "Advance Notice") detailing preliminary 2018 Medicare Advantage benchmark payment rates. As is customary, CMS has invited public comment on these preliminary rates before issuing its final rates for 2018 in April 2017. The Advance Notice proposes to provide a slight overall increase to Medicare rates for 2018 and we are continuing to evaluate the overall impact in our markets. At this time, CMS is not implementing any major proposed policy changes with respect to the exclusion of in home health risk assessments for risk adjustment purposes. If implemented, such change would result in significant additional funding declines for the Company. We will continue to evaluate proposed changes detailed in the Advance Notice, some of

which could adversely affect our plan benefit designs, market participation, growth prospects and earnings potential for our Medicare Advantage plans in the future.

Implementation of quality bonus for Star ratings—Beginning in 2012, Medicare Advantage plans with an overall "Star rating" of three or more stars (out of five) based on historical performance were eligible for a "quality bonus" in their basic premium rates. Plans receiving Star bonus payments are required to use the additional dollars to provide "extra benefits" for the plans' enrollees, to the extent necessary to maintain compliance with minimum loss ratio requirements, resulting in a competitive advantage for those plans rather than a direct financial impact. In addition, beginning in 2012, Medicare Advantage Star ratings affect the rebate percentage available for plans to provide additional member benefits (plans with quality ratings of 3.5 stars or above will have their rebate percentage increased from a base rate of 50% to 65% or 70%). In all cases, this rebate percentage is lower than the pre-ACA rebate percentage of 75%. Beginning in 2015, in order to qualify for bonus payments, plans must have a 4 STAR rating or higher. For 2017, the Company earned a 4.5-Star rating for its flagship TexanPlus® plan in Houston/Beaumont, which accounts for 57% of our December 31, 2016 membership, and maintained a 4-Star rating for our Today's Options PPO plan in New York and Maine. Collectively, over 70% of our members are in Plans with a Star rating of 4.0 or greater. A summary of these ratings is presented below:

Contract	Plan Name	Location	January 31, 2017 Members (000's)	2017 Star Rating
H4506	Texan Plus HMO	Southeast Texas—Houston/Beaumont	69.2	4.5
H2775	Today's Options PPO	Northeast—New York & Maine	19.8	4.0
H0174	Texan Plus D-SNP	Southeast Texas	0.5	4.0
H2816	Today's Options Network PFFS	Northeast—New York & Maine	27.6	3.5
H5656	Texan Plus HMO	North Texas—Dallas	2.4	3.0
			119.5	

Notwithstanding continued efforts to improve or maintain our Star ratings and other quality measures, there can be no assurances that we will be successful. Accordingly, our plans may not be eligible for full level quality bonuses or increased rebates, which could adversely affect the benefits such plans can offer, reduce membership, and reduce profit margins.

In addition, CMS has indicated that plans with a Star rating of less than 3.0 for three consecutive years may be subject to termination. While we do not currently have any plans with a rating below 3.0, our inability to maintain Star ratings of 3.0 or better for a sustained period of time could ultimately result in plan termination by CMS which could have a material adverse impact on our business, cash flows and results of operations. Also, the CMS Star ratings/quality scores may be used by CMS to pay bonuses to Medicare Advantage plans that enable those plans to offer improved benefits and/or better pricing. Furthermore, lower quality scores compared to our competitors may result in us losing potential new business in new markets or dissuading potential members from choosing our plan in markets in which we compete. Lower quality scores compared to our competitors could have a material adverse effect on our rate of growth.

Stipulated minimum MLRs—Beginning in 2014, the ACA stipulates a minimum MLR of 85% for Medicare Advantage plans. This MLR which is calculated at a plan level, takes into account benefit costs, quality initiative expenses, the ACA fee and taxes. Financial and other penalties may result from failing to achieve the minimum MLR ratio. For the years ended December 31, 2016, 2015 and 2014 our Medicare Advantage plans exceeded the minimum MLR, as defined by CMS. Complying with such minimum ratio by increasing our medical expenditures or refunding any shortfalls to the federal government could have a material adverse effect on our operating margins, results of operations, and our statutory capital.

Non-deductible health insurance industry fee ("ACA Fee")—Beginning in 2014, the new healthcare reform legislation imposed an annual aggregate health insurance industry fee of $8.0 billion, increasing to $11.3 billion in 2016 (with increasing annual amounts thereafter) on health insurance premiums, including Medicare Advantage premiums, that is not deductible for income tax purposes. In 2017, the ACA Fee has been suspended for one year. Our share of the ACA Fee is based on our pro rata percentage of premiums written during the preceding calendar year compared to the industry as a whole, calculated annually. The ACA Fee, first expensed and paid in 2014, adversely affects the profitability of our Medicare Advantage business and could have a material adverse effect on our results of operations. For our continuing operations, we paid fees of $21.7 million, $25.5 million and $22.9 million in the years ended December 31, 2016, 2015 and 2014, respectively, based on prior year net written premiums. We do not expect to pay any fees in 2017, due to the one year suspension of the ACA fee. Pursuant to GAAP, the liability for the ACA Fee will be estimated and recorded in full once the entity provides qualifying health insurance in the corresponding period with a corresponding deferred cost that is to be amortized to expense on a straight-line basis over the applicable calendar year. For statutory reporting purposes, the ACA Fee will be expensed on January 1 in the year of payment, rather than amortized to expense over the year. The ACA Fee is included in other operating costs; however, will be factored in when calculating the stipulated minimum MLR. Our effective income tax rate increased in 2014, and will remain at a higher level in future years in which the ACA fee is assessed.

Coding intensity adjustments—Under the ACA, the coding intensity adjustment instituted in 2010 became permanent, resulting in mandated minimum reductions in risk scores of 4.91% in 2014 increasing each year to 5.91% in 2018. These coding adjustments may adversely affect the level of payments from CMS to our Medicare Advantage plans.

Limitation on the federal tax deductibility of compensation earned by individuals—Beginning in 2013, with respect to services performed during 2010 and afterward, for health insurance companies, the federal tax deductibility of compensation is limited under Section 162(m)(6) of the Code to $500,000 per individual and does not contain an exception for "performance-based compensation." In September 2014, the Internal Revenue Service issued final regulations on this compensation deduction limitation which provided additional information regarding the definition of a health insurance issuer. Based on our analysis of the final regulations, we believe we are not subject to the limitation. As a result, during the fourth quarter of 2014, we recorded a tax benefit of $3.2 million related to prior years and $1.7 million related to the first nine months of 2014. Prior to receiving the final regulations, our application of this limitation had increased our effective tax rate by approximately 60 basis points for the year ended December 31, 2013 and 200 basis points for the year ended December 31, 2012. However, there is a risk that the Internal Revenue Service or other regulators may disagree with our interpretation, which could result in higher taxes.

Accountable Care Organizations—The ACA established Medicare ACOs, as a tool to improve quality and lower costs through increased care coordination in the FFS program. CMS established the MSSP to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. To date, we have partnered with numerous groups of healthcare providers and currently participate in sixteen MSSP ACOs and two Next Generation ACOs. ACOs are entities that contract with CMS to serve the FFS population with the goal of better care for individuals, improved health for populations and lower costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. We provide a variety of services to the ACOs, including care coordination, analytics and reporting, technology and other administrative services to enable these physicians and their associated healthcare providers to deliver better quality care, improved health and lower healthcare costs for their Medicare FFS patients.

Under the MSSP, CMS will not make any payments to ACOs for a measurement year until the second half of the following year, which will negatively impact our cash flows. In order to receive revenues from CMS under the MSSP, the ACO must meet certain minimum savings rates (i.e. save the federal government money) and meet certain quality measures. More specifically, an ACOs medical expenses for its assigned beneficiaries during a relevant measurement year must be below the benchmark established by CMS for such ACO. On the quality side, for 2017, the MSSP requires ACOs to meet thirty-one quality measures, which CMS may vary from time to time. Notwithstanding our efforts, our ACOs may be unable to meet the required savings rates or may not satisfy the quality measures, which may result in our receiving no revenues and losing our substantial investment. In addition, as the MSSP is a new program, it presents challenges and risks associated with the timeliness and accuracy of data and interpretation of complex rules, which may impact the timing and amount of revenue we can recognize and could have a material adverse effect on our ability to recoup any of our investment in this new business. Further, there can be no assurance that we will maintain positive relations with our ACO partners which may result in certain of the ACOs terminating our relationship, which will result in a potential loss of our investment.

On June 4, 2015, CMS released a final rule updating provisions related to the MSSP in the second contract period for years 2016-2019. This final rule made several changes, including allowing ACOs to participate in Track 1 for a second agreement period with the same sharing rate (up to 50%), establishing a new Track 3 with two-sided risk with additional flexibilities, providing new beneficiary-level claims data that will improve overall ACO information, and easing certain administrative requirements.

Additionally, the CMS Center for Medicare and Medicaid Innovation, or CMMI, launched the Next Generation ACO Model, a new value-based payment model that encourages providers to assume greater risk and offers enhanced rewards for coordinating the healthcare of Medicare fee-for-service beneficiaries. The Next Generation ACO Model provides ACOs with additional tools not found in the MSSP but used in the Medicare Advantage program to improve quality and lower cost, including preferred networks, negotiated discounts and beneficiary incentives. The Next Generation ACO Model offers two risk arrangements with prospectively assigned beneficiaries under which a Next Generation ACO can share up to 80% or 100% of savings (losses) generated in each performance year depending on the financial arrangement selected by the ACO.

In addition, CMS, the US Office of Inspector General, the Internal Revenue Service, the Federal Trade Commission, the US Department of Justice, and various states have adopted or are considering adopting new legislation, rules, regulations and guidance relating to formation and operation of ACOs. Such laws may, among other things, require ACOs to become subject to financial regulation such as maintaining deposits of assets with the states in which they operate, the filing of periodic reports with the insurance department and/or department of health, or holding certain licenses or certifications in the jurisdictions in which the ACOs operate. Failure to comply with legal or regulatory restrictions may result in CMS terminating an ACOs agreement with CMS and/or subjecting an ACO to loss of the right to engage in some or all business in a state, payment of fines or penalties, or may implicate federal and state fraud and abuse laws relating to anti-trust, physician fee-sharing arrangements, anti-kickback prohibitions or prohibited referrals, any of which may adversely affect our operations and/or profitability.

Special Cash Dividend

On October 26, 2015, we paid a special cash dividend of $0.75 per share, to shareholders of record on October 19, 2015. The total dividend was $63.0 million. This dividend is a liquidating dividend and was recorded as a reduction of additional paid in capital.

Membership

The following table presents our membership in Medicare Advantage products:

	January 31, 2017	December 31, 2016
	(in thousands)	
Houston/Beaumont	69.2	65.8
Dallas	2.4	2.9
SETX dSNP	0.5	0.4
Texas	72.1	69.1
Upstate New York/Maine	47.4	45.4
Medicare Advantage	119.5	114.5

Segment Overview

Our business segments are based on product and consist of:

- Medicare Advantage; and
- MSO.

Our remaining segment, Corporate & Other, reflects the activities of our holding company, our prior participation in the New York Health Benefits Exchange, known as the Exchange, and other ancillary operations. Effective January 1, 2015, we are no longer participating in the Exchange. See Note 23—Business Segment Information in the Notes to Consolidated Financial Statements for a description of our segments.

We report intersegment revenues and expenses on a gross basis in each of the operating segments but eliminate them in the consolidated results. These intersegment revenues and expenses affect the amounts reported on the individual financial statement line items, but we eliminate them in consolidation and they do not change income before taxes. The most significant items eliminated relate to interest on intercompany loans which cross segments.

Results of Operations—Consolidated Overview

The following table reflects income (loss) from each of our segments and contains a reconciliation to reported net loss:

	For the year ended December 31,		
	2016	2015	2014
		(in thousands)	
Medicare Advantage(1)	$ 48,443	$ 21,480	$ 48,121
MSO(1)	(9,487)	(20,058)	(30,809)
Corporate & Other(1)	(37,331)	(40,287)	(49,378)
Net realized gains (losses)(1)	1,429	38,954	(649)
Income (loss) before income taxes(1)	3,054	89	(32,715)
Provision for (benefit from) income taxes	9,344	3,785	(6,107)
Loss from continuing operations	(6,290)	(3,696)	(26,608)
Income (loss) from discontinued operations	61,666	(160,273)	(2,859)
Net income (loss)	$ 55,376	$ (163,969)	$ (29,467)
Income (loss) per common share (diluted):			
Loss from continuing operations	$ (0.09)	$ (0.04)	$ (0.32)
Income (loss) from discontinued operations	0.87	(1.95)	(0.03)
Net income (loss)	$ 0.78	$ (1.99)	$ (0.35)

(1) We evaluate the results of operations of our segments based on income (loss) before realized gains and losses and income taxes. We believe that realized gains and losses are not indicative of overall operating trends. This differs from U.S. GAAP, which reflects the effect of realized gains and losses and income taxes in the determination of net income (loss). The schedule above reconciles our segment income (loss), to net income (loss) in accordance with U.S. GAAP.

Years ended December 31, 2016 and 2015

Loss from continuing operations for the year ended December 31, 2016 was $6.3 million, or $0.09 per diluted share, compared to a loss from continuing operations of $3.7 million, or $0.04 per diluted share, for the year ended December 31, 2015. These amounts include realized gains, net of taxes, of $1.5 million, or $0.02 per diluted share, and $25.3 million, or $0.31per diluted share in 2016 and 2015, respectively.

Our Medicare Advantage segment generated income before income taxes of $48.4 million for the year ended December 31, 2016; an increase of $27.0 million compared to the year ended December 31, 2015. The increase in earnings was driven primarily by membership growth, lower MBR, particularly in the Northeast, and a decrease in ACA fee expense; partially offset by lower net investment income, and a membership-driven increase in medical expenses, commissions and general expenses. The year ended December 31, 2016 included $7.6 million of net favorable prior period items compared to $4.0 million of net favorable items for the year ended December 31, 2015. Effective January 1, 2016, we changed the way we estimate changes in risk-adjusted premiums receivable from CMS, which resulted in the accelerated recognition of approximately $9.2 million of additional current year premium revenue for the year ended December 31, 2016.

Our MSO segment generated loss before income taxes of $9.5 million for the year ended December 31, 2016 compared to a loss of $20.1 million for the year ended December 31, 2015, an improvement of $10.6 million. During the year ended December 31, 2016, we recognized $29.2 million

of net shared savings revenue from our MSSP ACOs. This compares with $20.9 million of program year 2014 net shared savings revenue recognized from 9 of our MSSP ACOs during the year ended December 31, 2015. We also recorded an estimated loss of $1.7 million in 2016 related to our Next Generation ACO, which began operations on January 1, 2016. Operating expenses for the year ended December 31, 2016 were $37.0 million compared to $40.9 million for the year ended December 31, 2015, reflecting fewer active ACOs in 2016.

Our Corporate & Other segment reported a loss of $37.3 million for the year ended December 31, 2016 compared to a loss of $40.3 million in 2015. This improvement was primarily due to lower legal and general corporate expenses partially offset by increased debt service costs as a result of our issuance of $115 million of Convertible Notes in June 2016.

Net realized gains for the year ended December 31, 2016 was $1.4 million compared to $39.0 million for the year ended December 31, 2015. The decrease is primarily due to 2015 realized gains of $29.6 million and $6.1 million on our cost-method minority investments in naviHealth and Data Driven Delivery Systems, Inc. (DDDS), respectively.

Our effective tax rate from continuing operations was a provision in excess of 100% for 2016 and 2015. The effective tax rate in 2016 and 2015 differs from the expected benefit of the 35% federal rate due to permanent items, primarily the ACA fee and preferred dividends, as well as state income taxes, net of non-recurring tax benefits. Non-recurring tax benefits included in income taxes amounted to $0.6 million and $6.5 million for the years ended December 31, 2016 and 2015, respectively. The 2016 benefit relates primarily to release of a reserve on foreign tax credits. The 2015 benefit primarily relates to $4.3 million in foreign tax credit carryforwards created in connection with the February 2015 sale of APS Puerto Rico, net of valuation allowance and a $2.4 million net capital loss created in connection with the Traditional Insurance business fair value adjustment, net of valuation allowance. Any utilization of these tax benefits in the future will require sufficient taxable income, of the appropriate character, from continuing sources; consequently, they are included in continuing operations.

Our after-tax income from discontinued operations was $61.7 million compared with a loss of $160.3 million for the years ended December 31, 2016 and 2015, respectively. Discontinued Operations includes the results of our Total Care Medicaid Plan and Traditional Insurance business, which were sold in August 2016 and APS Healthcare, which was sold during 2015. For further information on these businesses see Note 21—Discontinued Operations in the Notes to Consolidated Financial Statements.

Years ended December 31, 2015 and 2014

Loss from continuing operations for the year ended December 31, 2015 was $3.7 million, or $0.04 per diluted share, compared to a loss from continuing operations of $26.6 million, or $0.32 per diluted share, for the year ended December 31, 2014. These amounts include realized gains (losses), net of taxes, of $25.3 million, or $0.31 per diluted share, and $(1.8) million, or $(0.02) per diluted share in 2015 and 2014, respectively.

Our Medicare Advantage segment generated income before income taxes of $21.5 million for the year ended December 31, 2015; a decrease of $26.6 million compared to the year ended December 31, 2014. The decrease in earnings was primarily driven by higher utilization in our Northeast markets, expected lower membership as we exited non-core markets, a decrease in favorable prior period items and lower net investment income, partially offset by a decrease in commissions and general expense levels driven by our cost reduction initiatives. Our administrative expense ratio improved to 10.8% for the year ended December 31, 2015 from 12.1% in 2014 due to the cost reduction initiatives. The year ended December 31, 2015, included $4.0 million of net favorable prior period items compared to $33.0 million of favorable items for the year ended December 31, 2014.

Our MSO segment generated a loss before income taxes of $20.1 million for the year ended December 31, 2015, compared to a loss of $30.8 million for the year ended December 31, 2014, an improvement of $10.7 million. This improvement was primarily driven by a $7.5 million increase in shared savings revenue, as nine of our ACOs qualified for shared savings in program year 2014, compared with three ACOs in program year 2012/2013. Operating expenses for the year ended December 31, 2015 were $40.9 million compared to $44.2 million for the year ended December 31, 2014, reflecting fewer active ACOs in 2015.

Our Corporate & Other segment reported a loss of $40.3 million for the year ended December 31, 2015 compared to a loss of $49.4 million in 2014. This improvement was primarily due to corporate expense reduction initiatives, the discontinuation of our Exchange business and lower legal and debt service costs.

Net realized gains for the year ended December 31, 2015 included gains of $29.6 million and $6.1 million on our cost-method minority investments in naviHealth and Data Driven Delivery Systems, Inc. (DDDS), respectively.

Our effective tax rate from continuing operations was a provision in excess of 100% for 2015, compared with a benefit of 19% for 2014. The effective rate in 2015 and 2014 differs from the expected benefit of the 35% federal rate due to permanent items, primarily the ACA fee and preferred dividends, as well as state income taxes, net of non-recurring tax benefits. Non recurring tax benefits included in income taxes amounted to $6.5 million and $5.8 million for the years ended December 31, 2015 and 2014, respectively. The 2015 benefit primarily relates to $4.3 million in foreign tax credit carryforwards created in connection with the February 2015 sale of APS Puerto Rico, net of valuation allowance and a $2.4 million net capital loss created in connection with the Traditional Insurance fair value adjustment, net of valuation allowance. Utilization of these tax benefits will be as a result of sufficient taxable income, of the appropriate character, from continuing sources; therefore, they are included in continuing operations. The 2014 benefit primarily relates to the reversal of executive compensation previously considered non-deductible under Code section 162(m)(6) that resulted in the recording of a $3.2 million benefit for amounts considered non-deductible in our prior year tax return, recording of $1.3 million of foreign tax credits and a $0.7 million reserve release related to items on which the statute of limitations has expired.

Our after-tax loss from discontinued operations was $160.3 million and $2.9 million for the years ended December 31, 2015 and 2014, respectively. 2015 included a pre-tax write down to fair value of $149.2 million, on our Traditional Insurance business, which is considered held for sale at December 31, 2015, a realized loss of $17.4 million, pre-tax, on the sale of APS Healthcare's domestic and foreign businesses and a restructure charge of $5.6 million related to the shutdown of facilities, run out of the retained managed behavioral health (MBH) business and severance. The 2015 loss also included operating results for Traditional Insurance and Medicaid for the year and APS Healthcare for the period prior to the sale and a return to provision adjustment related to the 2014 income tax return of the disposed businesses. 2014 income represents operating results of the disposed businesses. For further information on these businesses, see Note 21—Discontinued Operations in the Notes to Consolidated Financial Statements.

Segment Results—Medicare Advantage

The following table presents the operating results of our Medicare Advantage segment:

	For the year ended December 31,		
	2016	2015	2014
		(in thousands)	
Net premiums	$ 1,366,716	$ 1,245,656	$ 1,393,444
Net investment and other income	9,693	10,379	16,880
Total revenue	1,376,409	1,256,035	1,410,324
Medical expenses	1,153,829	1,074,658	1,171,002
Amortization of intangible assets	933	2,110	2,600
ACA fee	21,725	25,464	22,910
Commissions and general expenses	151,479	132,323	165,691
Total benefits, claims and other deductions	1,327,966	1,234,555	1,362,203
Segment income before income taxes	$ 48,443	$ 21,480	$ 48,121

Our Medicare Advantage segment includes the operations of our Medicare coordinated care HMO, PPO and Network PFFS Plans (collectively known as the Plans). Our HMOs offer coverage to Medicare members primarily in Southeastern Texas (primarily Houston/Beaumont) and the Dallas area. Our PPO and Network PFFS Plans offer coverage primarily in upstate New York and Maine.

Years ended December 31, 2016 and 2015

Our Medicare Advantage segment generated income before income taxes of $48.4 million for the year ended December 31, 2016; an increase of $27.0 million compared to the year ended December 31, 2015. The increase in earnings was driven primarily by membership growth, lower MBR, particularly in the Northeast, and a decrease in ACA fee expense; partially offset by lower net investment income, and a membership-driven increase in medical expenses, commissions and general expenses. The year ended December 31, 2016 included $7.6 million of net favorable prior period items compared to $4.0 million of net favorable items for the year ended December 31, 2015. Effective January 1, 2016, we changed the way we estimate changes in risk-adjusted premiums receivable from CMS, which resulted in the accelerated recognition of approximately $9.2 million of additional current year premium revenue for the year ended December 31, 2016.

Net premiums. Net premiums for the Medicare Advantage segment increased by $121.1 million for the year ended December 31, 2016 compared with the same period in 2015, due to membership growth and an increase in premium per member driven by the 2016 change in our revenue recognition policy described above; partially offset by a $2.4 million reduction in favorable prior period items. The year ended December 31, 2016 included $13.3 million of net favorable prior period items recognized in net premiums as compared to $15.7 million of net favorable prior period items recognized for the year ended December 31, 2015.

Medical expenses. Medical expenses increased by $79.2 million for the year ended December 31, 2016 compared to the same period ended in 2015. The increase was driven by membership growth and increased utilization; partially offset by lower unfavorable prior period items. Medical expenses for the year ended December 31, 2016 included $5.7 million of net unfavorable items related to prior periods, compared to $11.7 million of net unfavorable items related to prior periods for the year ended December 31, 2015.

Quality improvement initiative costs are included in medical expenses in connection with the reporting of minimum medical loss ratios under the ACA. The following table provides a breakdown of medical expenses and the related medical benefits ratios:

	For the year ended December 31,			
	2016		2015	
	($ in thousands)			
Quality Initiatives	$ 24,179	1.8%	$ 25,341	2.1%
Medical Benefits	1,129,650	82.6%	1,049,317	84.2%
Total Benefits	$ 1,153,829	84.4%	$ 1,074,658	86.3%

Adjusting for the prior year items discussed above in net premiums and medical expenses, for the year ended December 31, 2016, our medical benefit ratio MBR, excluding quality initiative costs, was 83.0%. Our medical benefit MBRs for the year ended December 31, 2016, as reported and recast to exclude prior year items, are summarized in the table below:

	Reported	Recast
Texas HMOs Medical Benefit Ratio	82.5%	83.0%
Upstate New York/Maine Medical Benefit Ratio	83.3%	83.1%
Total Medicare Advantage	82.6%	83.0%

ACA fee. The ACA fee for the year ended December 31, 2016 amounted to $21.7 million or 1.6% of 2016 net premiums compared to $25.5 million or 2.0% of 2015 net premiums. The ACA fee is based on prior year premiums and is included in the calculation of minimum medical loss ratios under the ACA. The $3.7 million decrease in the ACA fee is due to lower full year premiums in 2015 compared to 2014, which was the result of lower membership in 2015 due to service area reductions effective January 1, 2015.

Commissions and general expenses. Commissions and general expenses for the year ended December 31, 2016 increased $19.2 million compared to the same period in 2015, primarily due to higher membership, sales and marketing costs, medical management evaluations and higher compensation costs. Our administrative expense ratio increased to 11.2% for the year ended December 31, 2016 compared to 10.8% for the year ended December 31, 2015.

Years ended December 31, 2015 and 2014

Our Medicare Advantage segment generated income before income taxes of $21.5 million for the year ended December 31, 2015; a decrease of $26.6 million compared to the year ended December 31, 2014. The decrease in earnings was primarily driven by higher utilization in our Northeast markets, expected lower membership as we exited non-core markets, a decrease in favorable prior period items and lower net investment income, partially offset by a decrease in commissions and general expense levels driven by our cost reduction initiatives. Our administrative expense ratio improved to 10.8% for the year ended December 31, 2015 from 12.1% in 2014 due to the cost reduction initiatives. The year ended December 31, 2015, included $4.0 million of net favorable prior period items compared to $33.0 million of favorable items for the year ended December 31, 2014.

In the Northeast markets, where we had a 35% increase in membership during 2015, and now have more than 45,000 members with a large concentration in upstate New York, we recorded an increased medical benefit ratio largely driven by higher utilization and a lag in adequate premium for new members.

Net premiums. Net premiums for the Medicare Advantage segment decreased by $147.8 million for the year ended December 31, 2015 compared to 2014, primarily as a result of exiting non-core markets. In the Northeast markets, where we had a 35% increase in membership during 2015, we had a lag in adequate premium for new members, as discussed above. Net premiums for the year ended December 31, 2015 included $15.7 million of favorable prior period items compared to $14.6 million of favorable prior period items for the year ended December 31, 2014.

Net investment and other income. Net investment and other income decreased by $5.6 million to $10.4 million for the year ended December 31, 2015 primarily due to lower invested asset levels resulting from the payment of dividends to the parent in 2015 and 2014.

Medical expenses. Medical expenses decreased by $96.3 million for the year ended December 31, 2015 compared to the year ended December 31, 2014. The decrease was primarily driven by our exit of non-core markets, offset by growth in our core markets, unfavorable prior period items and an increase in utilization in the Northeast markets, resulting in a Medicare Advantage medical benefit ratio of 86.3% for the year ended December 31, 2015 compared with 84.0% for the year ended December 31, 2014. Medical expenses for the year ended December 31, 2015 included $11.7 million of net unfavorable items related to prior periods, compared to $18.4 million of net favorable items related to prior periods for the year ended December 31, 2014.

Quality improvement initiative costs of $25.3 million in the year ended December 31, 2015 and $28.4 million in the year ended December 31, 2014 are included in medical expenses in connection with the reporting of minimum medical loss ratios under the ACA. The following table provides a breakdown of medical expenses and the related medical benefit ratios:

	For the year ended December 31,			
	2015		2014	
	($ in thousands)			
Quality Initiatives	$ 25,341	2.1%	$ 28,365	2.0%
Medical Benefits	1,049,317	84.2%	1,142,637	82.0%
Total Benefits	$ 1,074,658	86.3%	$ 1,171,002	84.0%

Adjusting for the prior year items discussed above in premiums and medical expenses, for the year ended December 31, 2015, our medical benefit MBR, excluding quality initiative costs was 84.3%. Our medical benefit MBRs for the year ended December 31, 2015, as reported and revised to exclude prior year items, are summarized in the table below:

	Reported	Recast(1)
Texas HMOs Medical Benefit Ratio	81.8%	82.0%
Upstate New York/Maine Medical Benefit Ratio	90.0%	89.4%
Total Medicare Advantage	84.2%	84.3%

(1) Recast excludes the impact of prior period items.

ACA fee. The ACA fee for the year ended December 31, 2015 amounted to $25.5 million, or 2.0% of 2015 net premiums compared to $22.9 million or 1.6% of net premiums for the year ended December 31, 2014. The ACA fee is included in the calculation of minimum medical loss ratios under the ACA. The increase in the ACA fee is due to the industry-wide total fee increasing from $8 billion in 2014 to $11.4 billion in 2015.

Commissions and general expenses. Commissions and general expenses for the year ended December 31, 2015 decreased $33.4 million compared to the year ended December 31, 2014, primarily

due to cost reduction initiatives and lower membership due to our exit of non-core markets. Our administrative expense ratio improved to 10.8% for the year ended December 31, 2015 from 12.1% in 2014 primarily as a result of our cost reduction efforts.

Segment Results—Management Services Organization

The following table presents the operating results of our MSO segment, consolidating the ACOs in which we participate with the operations of our Collaborative Health Systems, LLC (CHS) subsidiary:

	For the year ended December 31,		
	2016	2015	2014
		(in thousands)	
Shared Savings Revenue:			
Gross Shared Savings (1)	$ 39,838	$ 26,924	$ 20,357
ACO Partner Share	(10,606)	(6,040)	(6,982)
Net Shared Savings Revenue	29,232	20,884	13,375
Next Generation ACO Estimated Loss	1,700	—	—
Other operating income and expenses	37,019	40,942	44,184
Segment loss before income taxes	$ (9,487)	$ (20,058)	$ (30,809)

(1) Amounts represent shared savings revenues recorded in the current year related to the prior program year.

Our MSO segment supports our physician partnerships in the development of value based healthcare models, such as ACOs, with a variety of capabilities and resources including technology, analytics, clinical care coordination, regulatory compliance and program administration. This segment includes our CHS subsidiary and affiliated ACOs. CHS works with physicians and other healthcare professionals to operate ACOs under the MSSP. CHS provides these ACOs with care coordination, analytics and reporting, technology and other administrative capabilities to enable participating providers to deliver better care and lower healthcare costs for their Medicare fee-for-service beneficiaries. The Company provides funding to CHS to support the operating activities of CHS and the ACOs.

We have determined that we cannot consolidate the ACOs and therefore, include our share of their operating results in Equity in losses of unconsolidated subsidiaries on our Consolidated Statements of Operations. In the table above, we have presented our share of the results of the ACOs combined with the results of CHS to provide a better understanding of our MSO segment's results of operations.

The MSSP is relatively new and therefore has limited historical experience. This impacts our ability to accurately accumulate and interpret the data available for calculating the ACOs' shared savings. Therefore, during 2016 and 2015, we recognized our portion of ACO shared savings revenue when notified by CMS. Such notification lags the Program Year to which the revenue relates by six to nine months. Revenue for the 2015 Program Year, which ended on December 31, 2015, was recorded in the quarter ended June 30, 2016, and trued up in the quarter ended September 30, 2016. Revenue for the 2014 Program Year, which ended on December 31, 2014, was recorded in the quarter ended June 30, 2015. Based on the ACO operating agreements, we bear all costs of the ACO operations until revenue is recognized. At that point, we generally share in up to 100% of the revenue to recover our costs incurred. Any remaining revenue is generally shared equally with our ACO provider partners.

During 2016, we operated one ACO under the new Next Generation ACO Model. This Next Generation ACO receives different beneficiary information from CMS during the year than the MSSP

ACOs. During 2016, we were able to use this information to estimate Program Year 2016 revenue for this Next Generation ACO, but determined, based on the information available, that this ACO would not generate any shared savings. Based on our analysis, we accrued a $1.7 million estimated loss for 2016.

Years ended December 31, 2016 and 2015

Our MSO segment generated loss before income taxes of $9.5 million for the year ended December 31, 2016 compared to a loss of $20.1 million for the year ended December 31, 2015, an improvement of $10.6 million. During the year ended December 31, 2016, we recognized $29.2 million of net shared savings revenue from our MSSP ACOs. $28.5 million related to program year 2015 shared savings from 10 of our MSSP ACOs. 2016 revenue also includes additional program year 2014 revenue of $0.7 million recognized in the first quarter of 2016 as a result of the restructuring of the program year 2014 shared savings distribution for two MSSP ACOs during the first quarter of 2016. This compares with $20.9 million of program year 2014 net shared savings revenue recognized from 9 of our MSSP ACOs during the year ended December 31, 2015. We also recorded an estimated loss of $1.7 million in 2016 related to our Next Generation ACO, which began operations on January 1, 2016. Operating expenses for the year ended December 31, 2016 were $37.0 million compared to $40.9 million for the year ended December 31, 2015, reflecting fewer active ACOs in 2016.

On July 29, 2016, CMS informed us that our MSSP ACOs generated $97 million in gross savings for program year 2015. This compares to $80 million in gross savings for program year 2014, which we reported in the second quarter of 2015. 10 of our ACO's qualified for shared savings payments, compared to 9 in program year 2014, and received payments of $39.8 million, compared to $26.9 million in program year 2014. Our share of these payments for 2016, after payments to our physician partners of $11.3 million, is $28.5 million, compared to $20.9 million in 2015, and is reflected in equity in earnings (losses) of unconsolidated subsidiaries in our consolidated statements of operations. We received these payments during the third quarter of 2016.

Years ended December 31, 2015 and 2014

Our MSO segment generated a loss before income taxes of $20.1 million for the year ended December 31, 2015, compared to a loss of $30.8 million for the year ended December 31, 2014, an improvement of $10.8 million. This improvement was primarily driven by a $7.5 million increase in shared savings revenue, as nine of our ACOs qualified for shared savings in program year 2014, compared with three ACOs in program year 2012/2013. Operating expenses for the year ended December 31, 2015 were $40.9 million compared to $44.2 million for the year ended December 31, 2014, reflecting fewer active ACOs in 2015.

On July 30, 2015, CMS informed us that our 23 Medicare Shared Savings Program, or MSSP, ACOs which were active in 2014, generated $80 million in gross savings for program year 2014. This compares to $66 million in gross savings for 2012/2013, the first program period of the MSSP, which comprised up to 21 months and which we reported in the third quarter of 2014. For these 23 ACOs, the results showed that:

- 9 ACOs, serving more than 105,000 Medicare beneficiaries, including our flagship ACO in Houston, qualified for shared savings totaling $26.9 million. This compares to $20.4 million in shared savings paid to ACOs for the first program year 2012/2013, which was longer. Our share of these payments, recorded in the second quarter of 2015, after payments to our physician partners of $6.0 million, increased to $20.9 million, which is reflected in equity in losses of unconsolidated subsidiaries in our consolidated statements of operations. We received these payments during October 2015;

- 8 additional ACOs achieved savings but did not exceed the Minimum Savings Rate, known as MSR. Of those eight, four missed the MSR by less than 1%; and

- Quality scores improved for all ACOs, which indicates improved healthcare management particularly for our chronically ill beneficiaries.

Segment Results—Corporate & Other

The following table presents the primary components comprising the loss for the segment:

	For the year ended December 31,		
	2016	2015	2014
		(in thousands)	
Net premiums	$ —	$ 316	$ 1,291
Net investment income	305	3,067	5,365
Fee and other income	2,014	3,809	1,837
Total revenue	2,319	7,192	8,493
Claims and other benefits	—	(184)	1,560
Interest expense	8,140	5,289	6,999
Commissions and general expenses	31,510	42,374	49,312
Total benefits, claims and other deductions	39,650	47,479	57,871
Segment loss before income taxes	$ (37,331)	$ (40,287)	$ (49,378)

Corporate & Other reflects the activities of our holding company, our participation in the Exchange, and other ancillary operations. Effective January 1, 2015, we are no longer participating in the Exchange.

Years ended December 31, 2016 and 2015

Our Corporate & Other segment reported a loss of $37.3 million for the year ended December 31, 2016 compared to a loss of $40.3 million in 2015. This improvement was primarily due to lower legal and general corporate expenses partially offset by increased debt service costs as a result of our issuance of $115 million of Convertible Notes in June 2016.

Net premiums. Net premiums in 2015 represented a larger than anticipated risk score adjustment, net of risk corridor related to the Exchange business, which we exited at the end of 2014.

Net investment income. Net investment income decreased by $2.9 million for the year ended December 31, 2015 compared to 2014. In 2015, we received a distribution on a cost method minority investment of $2.0 million.

Fee and other income. Fee and other income decreased by $1.8 million for the year ended December 31, 2016 compared to 2015 primarily due to lower revenues from transition services agreements entered into in connection with the sale of our Traditional Insurance and Total Care Medicaid businesses in 2016 compared with the APS Healthcare businesses in 2015. These additional revenues are offset by expenses included in commissions and general expenses.

Claims and other benefits. Claims and other benefits in 2015 represented recoveries from the Federal transitional reinsurance program related to the Exchange business in 2014.

Interest expense. Interest expense increased by $2.9 million for the year ended December 31, 2016 compared to 2015 due to the convertible notes issued in June 2016.

Commissions and general expenses. Commissions and general expenses decreased by $10.9 million for the year ended December 31, 2016 compared to 2015. This decrease was driven by reductions in general corporate expenses related to our expense reduction initiatives and lower legal costs as well as lower costs associated with the transition services agreements, totaling $9.1 million. In addition, 2015 included costs associated with accelerated vesting of stock compensation expense for terminated employees, and accelerated amortization of debt issuance costs in connection with our loan repayments and amendment to our revolving credit facility totaling $3.6 million. These reductions were partially offset by increased corporate development costs related to our various sales processes and lower recoveries of agents balances.

Years ended December 31, 2015 and 2014

Our Corporate & Other segment reported a loss of $40.3 million for the year ended December 31, 2015 compared to a loss of $49.4 million in 2014. This improvement was primarily due to corporate expense reduction initiatives, the discontinuation of our Exchange business and lower legal and debt service costs.

Net premiums. Net premiums decreased by $1.0 million for the year ended December 31, 2015 compared to 2014 as a result of the Company no longer participating in the Exchange. However, in 2015 we received a larger than anticipated risk score adjustment, net of risk corridor related to the Exchange business in 2014.

Net investment income. Net investment income decreased by $2.3 million for the year ended December 31, 2015 compared to 2014. In 2014, we received a distribution on a cost method minority investment of $2.7 million compared to $2.0 million in 2015. In addition, in 2014, the segment received investment income on a loan to our APS Healthcare subsidiary which is reported in discontinued operations.

Fee and other income. Fee and other income increased by $2.0 million for the year ended December 31, 2015 compared to 2014 primarily due to revenues from transition services agreements entered into in connection with the sale of our APS Healthcare businesses. These additional revenues are offset by expenses included in commissions and general expenses. All transition services were complete by December 31, 2015.

Claims and other benefits. Claims and other benefits decreased by $1.7 million for the year ended December 31, 2015 compared to 2014, due to the Company no longer participating in the Exchange. Additionally, in 2015, we received larger than anticipated recoveries from the Federal transitional reinsurance program related to the Exchange business in 2014.

Interest expense. Interest expense decreased by $1.7 million for the year ended December 31, 2015 compared to 2014 due to the term loan prepayments made on March 31, 2015 and October 14, 2015.

Commissions and general expenses. Commissions and general expenses decreased by $7.0 million for the year ended December 31, 2015 compared to 2014. This decrease was driven by reductions in general corporate expenses related to our expense reduction initiatives and lower legal costs which totaled $23.8 million. These reductions were partially offset by costs associated with the transition services agreements, accelerated vesting of stock compensation expense for terminated employees, lower recoveries of agents balances previously written off and accelerated amortization of debt issuance costs in connection with our loan repayments and amendment to our revolving credit facility totaling $16.8 million.

Discontinued Operations

The following table presents the primary components comprising income (loss) from discontinued operations:

	For the year ended December 31,		
	2016	2015	2014
		(in thousands)	
Medicaid:			
Operating results	$ (4,253)	$ 105	$ 2,635
Gain on sale	20,407	—	—
	16,154	105	2,635
Traditional Insurance:			
Operating results	$ 10,942	$ (16,278)	$ 2,507
Realized gains (losses)	160	44	(733)
Gain (loss) on sale	486	(149,153)	—
	11,588	(165,387)	1,774
APS Healthcare	39,921	(23,089)	(5,619)
Income (loss) before income taxes	$ 67,663	$ (188,371)	$ (1,210)

Discontinued Operations includes the results of our Medicaid, Traditional Insurance and APS Healthcare businesses. For additional information on the sale of these businesses, see Note 21—Discontinued Operations.

Years ended December 31, 2016 and 2015

Universal American reported income from discontinued operations of $67.7 million for the year ended December 31, 2016 compared with a loss of $188.4 million in 2015.

Medicaid—Operating Results: Medicaid had an operating loss of $4.3 million for the year ended December 31, 2016 compared to income of $0.1 million for the same period in 2015. This decrease was primarily due to higher claims costs, including unfavorable prior period items and higher expenses during 2016.

Medicaid—Gain on Sale: On August 1, 2016, we completed the sale of TONY, which operates the Total Care Medicaid plan, to Molina for an adjusted purchase price of $38.0 million, resulting in a pre-tax gain of $20.4 million.

Traditional Insurance—Operating Results: Traditional Insurance had operating income of $10.9 million for the year ended December 31, 2016 compared with a loss of $16.3 million for the same period in 2015. Earnings in 2016 were driven by the absence of DAC amortization in 2016, since all DAC was written off at December 31, 2015 in connection with the Traditional Insurance fair value adjustment as well as lower levels of operating expenses, partially offset by lower earnings from a smaller block of in force business. The 2015 loss was primarily driven by an increase in claim reserves on our Disability Income line of business as a result of an updated claim termination study, as well as recording additional amortization of our deferred acquisition costs (DAC) asset as a result of loss recognition testing deficiencies.

Traditional Insurance—Gain (Loss) on Sale: The gain recorded in 2016 includes the reclassification of $4.8 million of accumulated other comprehensive income (AOCI) related to the sale of the Traditional Insurance business to adjust the cumulative loss on the transaction. This was partially offset by a $1.6 million adjustment to reflect the early cash settlement of the earn out and a

$2.3 million reduction of sale procceds related to the final balance sheet true up with the buyer. As of December 31, 2015, we determined that this business should be classified as held for sale and reported in discontinued operations. Consequently, the related assets and liabilities at December 31, 2015 were adjusted to fair value, resulting in a pre-tax loss of $149.2 million, including the write off of $60.4 million in deferred acquisition costs and other intangible assets.

APS Healthcare: 2016 amounts include earn-out revenues and litigation settlement, while 2015 amounts represent losses on the sale of our APS Puerto Rico business of $0.4 million and on the sale of our APS domestic business of $17.0 million, as well as a restructure charge of $5.6 million related to the sale of the domestic business See Note 22—Commitments and Contingencies for additional information.

Years ended December 31, 2015 and 2014

Universal American reported a loss from discontinued operations of $188.4 million for the year ended December 31, 2015 compared with a loss of $1.2 million in 2014.

Medicaid—Operating Results: Our Medicaid segment generated income before income taxes of $0.1 million for the year ended December 31, 2015 compared to income of $2.6 million for the year ended December 31, 2014. This decrease was as a result of higher medical benefits primarily related to increased inpatient utilization and unfavorable claims run-out from prior periods as well as an increase in operating expenses, partially offset by an increase in net premiums due to higher state capitation rates.

Traditional Insurance—Operating Results: Traditional Insurance had an operating loss of $16.3 million for the year ended December 31, 2015 compared with a gain of $2.5 million for the same period in 2014. The 2015 loss was primarily driven by an increase in claim reserves on our Disability Income line of business as a result of an updated claim termination study, as well as recording additional amortization of our deferred acquisition costs (DAC) asset as a result of loss recognition testing deficiencies.

Traditional Insurance—Gain (Loss) on Sale: As of December 31, 2015, we determined that this business should be classified as held for sale and reported in discontinued operations. Consequently, the related assets and liabilities at December 31, 2015 were adjusted to fair value, resulting in a pre-tax loss of $149.2 million, including the write off of $60.4 million in deferred acquisition costs and other intangible assets.

APS Healthcare: During 2015, we recorded losses on the sale of our APS Puerto Rico business of $0.4 million and on the sale of our APS domestic business of $17.0 million, as well as a restructure charge of $5.6 million related to the sale of the domestic business and operating results prior to sale. In connection with the sale, we retained certain office space which we have exited and certain managed behavioral health, or MBH, contracts which we have terminated and are operating at a loss as the business runs off. Our restructure charge for facilities represents the estimated costs to close the facilities, including lease buyout costs and rent costs, net of estimated sublease revenue, on non-cancellable leases prior to termination. The related leases run through 2021. The charge related to the MBH contracts represents the estimated operating losses on the terminated contracts through the end of the contractual period, March 31, 2016. 2014 results included $15.9 million of litigation and settlement costs related to APS Healthcare matters, partially offset by an operating profit of $10.3 million.

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Contractual Obligations and Commercial Commitments

Our contractual obligations as of December 31, 2016, are shown below.

Contractual Obligations	Payments Due by Period				
	Total	2017	2018 - 2019	2020 - 2021	Thereafter
			(in thousands)		
Continuing operations:					
Convertible Senior Notes due 2021	$ 135,700	$ 4,600	$ 9,200	$ 121,900	$ —
Series A mandatorily redeemable preferred shares (1)	41,700	41,700	—	—	—
Operating Lease Obligations	13,845	4,531	5,352	3,576	386
Purchase Obligations(2)	17,697	4,194	8,843	4,660	—
Policy and contract claims	83,021	74,609	8,412	—	—
Total	$ 291,963	$ 129,634	$ 31,807	$ 130,136	$ 386

(1) These obligations include preferred dividends and the final payment of principal of $40 million in April 2017.

(2) Reflects minimum obligations on our outsourcing contracts, See "Outsourcing Arrangements" in Part 1, Item 1 of this annual report on Form 10-K. The amount of service provided under the contracts and the levels of business processed affect our actual monthly payments. The above table includes only the minimum amounts required under the contracts. Based upon anticipated future service levels, we expect that our total actual payments for purchase obligations will exceed the amounts presented in the above schedule.

Liquidity and Capital Resources

Sources and Uses of Liquidity to the Parent Company, Universal American Corp. We require cash at our parent company to support the operations and growth of our subsidiaries, fund new business opportunities through acquisitions or otherwise, fund debt service and pay the operating expenses necessary to function as a holding company, as applicable insurance department regulations require us to bear our own expenses.

The parent company's ongoing sources and uses of liquidity are derived primarily from the following:

- dividends from and capital contributions to our Insurance and HMO subsidiaries—During the year ended December 31, 2016, SelectCare of Texas, Inc. ("SCOT") paid a $9.6 million dividend on July 21, 2016. No other dividends were declared or paid during 2016. In the third quarter of 2016, we made a capital contribution of $0.6 million to our Medicaid subsidiary, TONY, prior to its sale to Molina, and a $0.1 million of capital contribution to our Texas-based dual-eligible special needs plan ("dSNP"), Today's Options of Texas, Inc. ("TOTX").

- loans from and interest payments to our Insurance subsidiaries to support investments in our ACO business—During 2013, our Insurance subsidiaries loaned $22.0 million to our parent company. The parent company repaid $9.0 million of this loan in April 2015. The remaining $13.0 million loan payable was paid in August 2016. During the year ended December 31, 2016, the parent company paid interest totaling $0.3 million to our Insurance subsidiaries on such loans.

- the cash flows of our other subsidiaries, including our Medicare Advantage management service organization—Net cash flows available to our parent company amounted to approximately $17.8 million during the year ended December 31, 2016.

- the cash flows of our ACO business and other growth initiatives—For the year ended December 31, 2016, we funded expenses of approximately $36.4 million, pre-tax, related to our ACO business. Additionally, in September 2016, we received $39.8 million of gross proceeds from CMS for the 2015 program year. We made distributions from these proceeds to our physician partners totaling $6.4 million in the fourth quarter of 2016 with an additional $4.9 million to be paid in the first quarter of 2017.

- payment of dividends to holders of our mandatorily redeemable preferred shares—In the year ended December 31, 2016, we paid $3.4 million of dividends to holders of our mandatorily redeemable preferred shares. The $40 million face value of those shares will be redeemed at their maturity date in the second quarter of 2017, or earlier as part of the WellCare transaction.

- payment of debt principal, interest and fees related to our convertible senior notes.—in December 2016, we made our first interest payment of $2.1 million on our convertible notes.

- payment of certain corporate overhead costs and public company expenses, net of revenues, which amounted to $25.2 million for the year ended December 31, 2016.

In addition, the parent company from time-to-time engages in corporate finance activities that generate the following sources and uses of liquidity:

- issuance of convertible senior notes—On June 27, 2016, we completed an offering of $115.0 million of our 4.00% Convertible Senior Notes due 2021 (the "Convertible Notes"). The Convertible Notes are senior unsecured obligations of the Company. Interest on the Convertible Notes is payable on June 15 and December 15 of each year, commencing on December 15, 2016 until their maturity date of June 15, 2021. We may not redeem the Convertible Notes prior to the maturity date. The notes are convertible, subject to certain conditions, into cash, shares of Universal American's common stock or a combination of cash and shares of Universal American's common stock, at Universal American's option. The initial conversion rate per $1,000 principal amount of notes is equivalent to 105.8890 shares of common stock, which is equivalent to a conversion price of approximately $9.44 per share, subject to adjustment in certain circumstances.

- repurchases of our common stock—We used the net proceeds from the Convertible Notes, together with cash on hand, to (i) repurchase all (a)11,011,515 shares of our common stock held by certain affiliates of Perry Capital ("Perry") and (b) 7,098,775 shares of our common stock held by certain affiliates of Welsh, Carson, Anderson & Stowe ("WCAS"), at a purchase price of $6.80 per share, for an aggregate purchase price of approximately $123.0 million, and (ii) repurchase 2,082,800 shares of our common stock for an aggregate purchase price of approximately $15.1 million from purchasers of the convertible notes in privately negotiated transactions.

- payment of dividends to shareholders—We do not currently pay a regular dividend to our shareholders, however, on October 26, 2015, we paid a special cash dividend of $0.75 per share. Payment of any future dividends would be dependent upon an evaluation of excess capital, as discussed below.

- proceeds from the sale of subsidiaries—On August 3, 2016 we completed the sale of our Traditional Insurance business to Nassau Re. At closing, we received $30.5 million in cash which, under the terms of the agreement, is subject to post-closing price adjustments based on actual capital and surplus of Constitution and Pyramid compared to the target statutory capital and surplus of $68.5 million. In October 2016, we received $11.4 million representing final settlement of potential earn-out payments from this sale and in January 2017 we received an additional $2.7 million in cash in final settlement of the post-closing balance sheet adjustments. On August 1, 2016, we completed the sale of all the outstanding equity interests of TONY, which

operates the Total Care Medicaid plan to Molina for an adjusted purchase price of $38.0 million. During 2015, we completed the sale of our APS Healthcare subsidiaries for $31.5 million in cash.

- proceeds from the sale of and distributions received on investments—In August 2015, we sold our interest in our cost-basis investment in naviHealth for $35.6 million and received cash proceeds of $33.1 million, with the balance of $2.5 million held in escrow, which was received in December 2016, and recorded a pre-tax realized gain of $29.6 million. In November 2015, we sold our interest in our cost-basis investment in DDDS for $6.6 million and received cash proceeds of $3.1 million, with the balance of $3.4 million representing the discounted fair value of a put option, exercisable in November 2018, and recorded a pre-tax realized gain of $6.1 million. In October 2016, we negotiated and received final settlement of this put option for $3.3 million. In addition, in 2015, we received a total of $2.0 million in cash distributions from DDDS.

- As of December 31, 2016, we had approximately $102.9 million of cash and investments in our parent company and unregulated subsidiaries.

We continually evaluate the potential use of any excess capital, which may include the following:

- reinvestment in existing businesses;

- acquisitions, investments or other strategic transactions;

- return to shareholders through share repurchase, dividend or other means;

- paydown of debt (as applicable); or

- other appropriate uses.

Any such use is dependent upon a variety of factors and there can be no assurance that any one or more of these uses will occur.

Sources and Uses of Liquidity of Our Subsidiaries

Insurance and HMO subsidiaries. We require cash at our insurance and HMO subsidiaries to meet our plan-related obligations and to pay operating expenses, including the cost of administration of the policies, and to maintain adequate capital levels. The primary sources of liquidity are premiums received from CMS and members and investment income generated by our invested assets.

The National Association of Insurance Commissioners, known as the NAIC, imposes regulatory risk-based capital, known as RBC, requirements on insurance companies. The level of RBC is calculated and reported annually. A number of remedial actions could be enforced if a company's total adjusted capital is less than 200% of authorized control level RBC. However, we generally consider target surplus to be 350% of authorized control level RBC. At December 31, 2016, all of our insurance and HMO subsidiaries had total adjusted capital in excess of our target of 350% of authorized control level RBC except for SCOT which had approximately 300%. Excess capital can be used by the insurance and HMO subsidiaries to make dividend payments to their respective holding companies, subject to certain restrictions, and from there to our parent company.

At December 31, 2016, we held cash and invested assets of approximately $256 million at our insurance and HMO subsidiaries that could readily be converted to cash. We believe that this level of liquidity is sufficient to meet our obligations and pay expenses.

During the twelve months ended December 31, 2016, SCOT paid a $9.6 million dividend on July 21, 2016. No other dividends were declared or paid during 2016. During 2015, our Insurance subsidiaries, Pyramid, Constitution, and Marquette (which was merged into Constitution in May 2015)

declared and paid dividends totaling approximately $92 million. These subsidiaries were sold as part of the sale of our Traditional Insurance subsidiaries to Nassau. See Note 12—Discontinued Operations in the Notes to Consolidated Financial Statements. In July 2015, SCOT paid a $9.0 million ordinary dividend. No other dividends were declared or paid by our other Insurance and HMO subsidiaries in 2015.

In the third quarter of 2016, we made a capital contribution of $0.6 million to our Medicaid subsidiary, TONY, and a $0.1 million of capital contribution to TOTX, in order to maintain its $5.0 million minimum capital requirement. No other capital contributions were made to our Insurance or HMO subsidiaries. In 2015, we funded a total of $17.1 million in capital contributions to one of our Insurance subsidiaries, which was merged into Constitution, one of the entities included in the sale of our Traditional Insurance business. During 2015, we made a total of $8.3 million in capital contributions to TONY in support of our Total Care Medicaid health plan; $3.2 million of which was done in the form of a surplus note, bearing interest at a rate of 5.0%. This note was converted to capital effective June 30, 2016 and all accrued and unpaid interest was settled in cash in July 2016. Additionally, in the fourth quarter of 2015, we made a $3.5 million capital contribution to TOTX.

Medicare Advantage Management Service Organizations. The primary sources of liquidity for these subsidiaries are fees collected from affiliates for performing administrative, marketing and management services for our Medicare Advantage business. The primary uses of liquidity are the payments for salaries and expenses associated with providing these services. We believe the sources of cash for these subsidiaries will exceed scheduled uses of cash and result in amounts available to dividend to our parent company.

Investments. We invest primarily in fixed maturity securities of the U.S. Government and its agencies, U.S. state and local governments, mortgage-backed securities and corporate fixed maturity securities with investment grade ratings of BBB– or higher by S&P or Baa3 or higher by Moody's Investor Service. As of December 31, 2016, approximately 99% of our fixed income investment portfolio had investment grade ratings from S&P or Moody's.

At December 31, 2016, cash and cash equivalents represent approximately 29% of our total cash and invested assets. The increase from 19% at December 31, 2015 is primarily driven by additional cash at the parent holding company. Approximately 50% of cash and invested assets were held in securities backed by the U.S. government or its agencies. The increase from 18% at December 31, 2015, is primarily due to the conversion of our "prime" money market fund holdings to U.S. government money market funds, which was driven by the money market fund reforms that went into effect in October 2016. The average credit quality of our total investment portfolio was AA– at December 31, 2016 and 2015.

The average book yield of our investment portfolio decreased to 2.2% at December 31, 2016 from 2.9% December 31, 2015, which was driven by the increase in our lower yielding cash balances at December 31, 2016 vs. 2015, continued lower reinvestment rates on our maturing fixed income portfolio and transfer of the higher yielding fixed maturity investments to discontinued operations in connection with the reinsurance of our Traditional Insurance business at American Progressive as we repositioned our portfolio after closing the transaction.

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Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with U.S. GAAP. The preparation of our financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts of reported by us in our consolidated financial statements and the accompanying notes. Critical accounting policies are ones that require significant subjective or complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. These estimates are based on information available at the time the estimates are made, as well as anticipated future events. Actual results could differ materially from these estimates. We periodically evaluate our estimates, and as additional information becomes available or actual amounts become determinable, we may revise the recorded estimates and reflect them in operating results. We believe that the following accounting policies are critical, as they involve the most significant judgments and estimates used in the preparation of our consolidated financial statements:

- policy and contract claim liabilities and benefit expense recognition;
- goodwill and other intangible assets;
- investment valuation;
- recognition of premium revenues and policy benefits—Medicare products; and
- income taxes.

Policy and contract claim liabilities and benefit expense recognition

We calculate and maintain reserves for the estimated future payment of claims to our policyholders using actuarial assumptions that are consistent with actuarial assumptions we use in the pricing of our products. The policy and contract claims liability for our Medicare Advantage policies include a liability for unpaid claims, including claims in the course of settlement, as well as a liability for incurred but not reported claims, known as IBNR. Benefit expenses are recognized in the period in which services are provided or claims are incurred and include an estimate of the cost of services and IBNR claims. Our net income depends upon the extent to which our actual claims experience is consistent with the assumptions we used in setting our reserves and pricing our policies. If our assumptions with respect to future claims are incorrect, and our reserves are insufficient to cover our actual losses and expenses, we would be required to increase our liabilities, resulting in reduced net income and stockholders' equity.

The following factors can affect these reserves and liabilities:

- economic and social conditions;
- inflation;
- hospital and pharmaceutical costs;
- changes in doctrines of legal liability;
- premium rate increases;
- extra-contractual damage awards; and
- other factors affecting healthcare and insurance generally.

Therefore, we establish the reserves and liabilities based on extensive estimates, assumptions and prior years' statistics. When we acquire other insurance companies or blocks of insurance, our assessment of the adequacy of acquired policy liabilities is subject to similar estimates and assumptions. Establishing reserves involves inherent uncertainties, and it is possible that actual claims could materially exceed our reserves and have a material adverse effect on our results of operations and financial condition.

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim payment and claim receipt patterns, as well as historical medical cost trends. Depending on the period for which we are estimating incurred claims, we apply a different method in determining our estimate. For aged service months (more than two or three months prior to the valuation date, depending on type of business), the key assumption we use in estimating our IBNR is that the completion factor pattern, adjusted for known changes in claim inventory levels and claim payment processes, remains consistent over a specified rolling period. This period, ranging from three to twelve months, is dependent on the type of business with respect to which we are estimating reserves or liabilities. Completion factors result from the calculation of the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. For recent service months (either two or three months, depending on type of business), we estimate the incurred claims primarily from a trend analysis based upon per member per month, known as PMPM, claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, product mix, and seasonality.

We use the completion factor method for aged service months because the historical percentage of claims processed for those months is at a level sufficient to produce a consistently reliable result. Conversely, for the most recent service months of incurred claims, the volume of claims processed historically is not at a level sufficient to produce a reliable result, which therefore requires that we examine historical trend patterns as the primary method of evaluation. Because cumulative claims payment development often fluctuates widely close to the incurred date of claims, estimates for the most recent service months of incurred claims are based on emerging claims trend experience. The amounts above reflect the estimated potential medical and other expenses payable based upon assumptions used in determining the loss ratio for the pricing of our products.

Medical cost trends potentially are more volatile than other segments of the economy. The principal intrinsic drivers of medical cost trends are:

- changes in the utilization of hospital facilities, physician services, prescription drugs, and new medical technologies, and
- the inflationary effect on the cost per unit of each of these expense components.

Other external factors may impact medical cost trends, such as:

- government-mandated benefits;
- other regulatory changes;
- an aging population;
- natural disasters and other catastrophes; and
- epidemics.

Factors internal to our company may also affect our ability to accurately predict estimates of historical completion factors or medical cost trends, such as:

- claims processing cycle times;
- changes in medical management practices; and
- changes in provider contracts.

We consider all of these factors in estimating IBNR and in estimating the PMPM claims trend for purposes of determining the reserve for the most recent three months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our

process and methods over time. We also consider the results of these studies in determining the reserve for the most recent three months. Each of these factors requires significant judgment by management.

Activity in the liability for policy and contract claims is as follows:

	For the years ended December 31,	
	2016	2015
	(in thousands)	
Balance at beginning of year	$ 86,976	$ 94,836
Less reinsurance recoverable	—	(394)
Net balance at beginning of period	86,976	94,442
Balances sold	—	(66)
Incurred related to:		
Current year	1,154,487	1,079,803
Prior year development	(660)	(5,329)
Total incurred	1,153,827	1,074,474
Paid related to:		
Current year	1,097,327	999,225
Prior year	60,578	82,649
Total paid	1,157,905	1,081,874
Balance at end of year	$ 82,898	$ 86,976

The liability for policy and contract claims decreased from $87.0 million to $82.9 million during the year ended December 31, 2016. The decrease in the liability was primarily attributable to the decrease in IBNR for our Medicare Advantage business due to lower inventory levels.

The prior year development incurred in the table above represents (favorable) or unfavorable adjustments as a result of prior year claim estimates being settled or currently expected to be settled, for amounts that are different than originally anticipated. This prior year development occurs due to differences between the actual medical utilization and other components of medical cost trends, and actual claim processing and payment patterns compared to the assumptions for claims trend and completion factors used to estimate our claim liabilities.

The claim reserve balances at December 31, 2015 settled during 2016 for $0.7 million less than originally estimated. This prior year development represents less than 0.1% of the incurred claims recorded in 2015.

The claim reserve balances at December 31, 2014 settled during 2015 for $5.3 million less than originally estimated. This prior year development represents 0.5% of the incurred claims recorded in 2014.

Sensitivity Analysis

The following table illustrates the sensitivity of our health IBNR payable at December 31, 2016 to identified reasonably possible changes to the estimated weighted average completion factors and healthcare cost trend rates. However, it is possible that the actual completion factors and healthcare

cost trend rates will develop differently from our historical patterns and therefore could be outside of the ranges illustrated below.

Completion Factor(1):			Claims Trend Factor(2):	
(Decrease) Increase in Factor	Increase (Decrease) in Net Health IBNR		(Decrease) Increase in Factor	(Decrease) Increase in Net Health IBNR
	($ in thousands)			
–3 %	$ 118		–3%	$ (4,808)
–2 %	79		–2%	(3,205)
–1 %	39		–1%	(1,603)
1 %	(39)		1%	1,603
2 %	(79)		2%	3,205
3 %	(118)		3%	4,808

(1) Reflects estimated potential changes in medical and other expenses payable, caused by changes in completion factors for incurred months prior to the most recent three months.

(2) Reflects estimated potential changes in medical and other expenses payable, caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent three months.

Goodwill and intangible assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. ASC 350, *Goodwill and Other Intangible Assets*, requires that goodwill balances be reviewed for impairment at the reporting unit level at least annually or more frequently if events occur or circumstances change that would indicate that a triggering event, as defined in ASC 350, has occurred. A reporting unit is defined as an operating segment or one level below an operating segment. Our reporting units are equivalent to our operating segments. We have goodwill assigned to our Medicare Advantage reporting unit.

We test goodwill for impairment annually, as of October 1 of the current year, or more frequently if circumstances suggest that impairment may exist. During each quarter, we perform a review of certain key components of our valuation of our reporting units, including the operating performance of the reporting units compared to plan (which is the primary basis for the prospective financial information included in our annual goodwill impairment test), our weighted average cost of capital and our stock price and market capitalization.

We estimate the fair values of our reporting units using discounted cash flows or other indications of fair value, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of cash flow (including significant assumptions about operations and target capital requirements), long term growth rates for determining terminal value, and discount rates. Forecasts and long term growth rates used for our reporting units are consistent with, and use inputs from, our internal long term business plan and strategy. During our forecasting process, we assess revenue trends, medical cost trends, operating cost levels and target capital levels. Significant factors affecting these trends include changes in membership, premium yield, medical cost trends, contract renewal expectations and the impact and expectations of regulatory environments.

Although we believe that the financial projections used are reasonable and appropriate, the use of different assumptions and estimates could materially impact the analysis and resulting conclusions. In addition, due to the long term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of healthcare reforms as discussed in Item 1, "Business—Regulation." For additional discussions regarding how the enactment or implementation of healthcare reforms and how other factors could affect our business and the related long term forecasts, see Item 1A, "Risk Factors" in Part I of this Annual Report on Form 10-K.

We use a range of discount rates that correspond to a market-based weighted average cost of capital. Discount rates are determined for each reporting unit based on the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. The most significant estimates in the discount rate determinations include the risk free rates and equity risk premium. Company specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty in regards to the reporting units' operations could cause these assumptions used in our analysis to change materially in the future. If our assumptions differ from actual, the estimates underlying our goodwill impairment tests could be adversely affected.

Future events that could have a negative impact on the levels of excess fair value over carrying value of our reporting units include, but are not limited to:

- decreases in business growth;
- decreases in forecasted margins;
- the loss of significant contracts;
- regulatory changes impacting the reporting unit;
- decreases in earnings projections;
- increases in the weighted average cost of capital; and
- increases in the amount of required capital for a reporting unit.

Negative changes in one or more of these factors, among others, could result in additional impairment charges.

To determine whether goodwill is impaired, we perform a multi-step impairment test. We perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if we elect to proceed directly with quantitative testing, we will measure the fair values of the reporting units and compare them to their carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, the second step of the impairment test is performed for the purposes of measuring the impairment. In this step, the fair value of the reporting unit is allocated to all of the assets and liabilities of the reporting unit to determine an implied goodwill value. This allocation is similar to a purchase price allocation performed in purchase accounting. If the carrying amount of the reporting unit goodwill exceeds the implied goodwill value, an impairment loss shall be recognized in an amount equal to that excess.

Our consolidated balance sheets include goodwill held in connection with our Medicare Advantage reporting unit of $68,393 at December 31, 2016 and 2015. There were no changes in carrying amounts during the years then ended.

Valuation of acquired intangible assets. Business combinations accounted for as a purchase result in the allocation of the purchase consideration to the fair values of the assets and liabilities acquired, including the present value of future profits and other identified intangibles, establishing these fair values as the new accounting basis. We base the fair values on an estimate of the cash flows of the identified intangible, discounted to reflect the present value of those cash flows. The discount rate we select depends upon the general market conditions at the time of the acquisition and the inherent risk in the transaction. We allocate purchase consideration in excess of the fair value of net assets acquired, including the present value of future profits and other identified intangibles, for a specific acquisition, to goodwill. We perform the allocation of purchase price in the period in which we consummate the purchase.

Amortizing intangible assets. We must estimate and make assumptions regarding the useful life we assign to our amortizing intangible assets. Set forth below are our annual amortization policies for each of the main categories of amortizing intangible assets which have an unamortized balance at December 31, 2016. All are being amortized over the estimated weighted average life of the related asset on a straight line basis.

Description	Weighted Average Life Remaining (Years)
Membership base	6
Provider contracts	<1
Non-compete	4

In accordance with ASC 350, *Intangibles—Goodwill and Other*, we periodically review amortizing intangible assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. If these estimates or their related assumptions change in the future, we may be required to record impairment losses for these assets.

Investment Valuation

We have engaged an investment advisor to manage a portion of our portfolio, perform investment accounting and provide valuation services. Securities prices are obtained by the advisor from independent pricing vendors, which are chosen based on their ability to support and price specified asset classes following the procedures outlined in the valuation policy reviewed and approved by us. The following are examples of typical inputs used by third party pricing vendors:

- reported trades;
- benchmark yields;
- issuer spreads;
- bids;
- offers; and
- estimated cash flows and prepayment speeds.

Based on the typical trading volumes and the lack of quoted market prices for fixed maturities, third party pricing services will normally derive the security prices through recent reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information as outlined above. If there are no recent reported trades, the third party pricing services may use matrix or model processes to develop a security price where the pricing

services develop future cash flow expectations based upon collateral performance, discounted at an estimated market rate. The pricing for mortgage-backed and asset-backed securities reflects estimates of the rate of future prepayments of principal over the remaining life of the securities. The pricing services derive these estimates based on the characteristics of the underlying structure and prepayment speeds previously experienced at the interest rate levels projected for the underlying collateral.

The investment advisor uses their own rules-based pricing system to evaluate the prices it receives from various pricing vendors to ensure the data adheres to certain vendor-to-vendor and day-to-day variance tolerances. Exceptions to the rules are monitored, investigated and challenged, as needed. We review and test the security pricing procedures used to value our fixed maturity portfolio on an ongoing basis. Our procedures include review of the investment valuation policy and understanding of the procedures used to obtain investment valuations and review of pricing controls at our investment advisor, including their Statements on Standards for Attestation Engagements 16 controls review report. We also test the prices provided by the advisor monthly by comparing the data to another independent pricing source and monitoring the change in prices from month to month and upon sale of the security. Significant changes or variances are investigated and explained. During the year ended December 31, 2016, we did not modify any price provided by the advisor.

We have also reviewed the advisor's pricing services' valuation methodologies and related sources, and have evaluated the various types of securities in our investment portfolio to determine an appropriate fair value hierarchy level based upon trading activity and the observability of market inputs. Based on the results of this evaluation and investment class analysis, we classified each price into Level 1, 2, or 3. We classified most prices provided by third party pricing services into Level 2 because the inputs used in pricing the securities are market observable.

Due to a general lack of transparency in the process that brokers use to develop prices, we classify most securities that have prices that are based on broker's prices as Level 3. We also classify internal model priced securities, primarily consisting of private placement asset-backed securities, as Level 3 because this model pricing reflects significant non-observable inputs.

We regularly evaluate the amortized cost of our investments compared to the fair value of those investments. We generally recognize impairments of securities when we consider a decline in fair value below the amortized cost basis to be other-than-temporary. The evaluation includes the intent and ability to hold the security to recovery, and we consider it on an individual security basis, not on a portfolio basis. We generally recognize impairment losses for mortgage-backed and asset-backed securities when an adverse change in the amount or timing of estimated cash flows occurs, unless the adverse change is solely a result of changes in estimated market interest rates. We also recognized impairment losses when we determine declines in fair values based on quoted prices to be other-than-temporary.

The evaluation of impairment is a quantitative and qualitative process, which is subject to risks and uncertainties and is intended to determine whether we should recognize declines in the fair value of investments in current period earnings. The principal risks and uncertainties are:

- changes in general economic conditions;
- the issuer's financial condition or near term recovery prospects;
- the effects of changes in interest rates or credit spreads; and
- the recovery period.

Our accounting policy, which follows ASC 320-65-1, requires that we assess a decline in the value of a security below its cost or amortized cost basis to determine if the decline is other-than-temporary.

- If we intend to sell a debt security, or it is more likely than not that we will be required to sell the debt security before recovery of its amortized cost basis, we recognize an other-than-temporary-impairment, or OTTI, in earnings equal to the entire difference between the debt security's amortized cost basis and its fair value.

- If we do not intend to sell the debt security and it is not more likely than not that we will be required to sell the debt security before recovery of its amortized cost basis, but the present value of the cash flows expected to be collected is less than the amortized cost basis of the debt security (referred to as the credit loss), an OTTI is considered to have occurred. In this instance, we bifurcate the total OTTI into the amount related to the credit loss, which we recognize in earnings, with the remaining amount of the total OTTI attributed to other factors (referred to as the noncredit portion) recognized as a separate component in other comprehensive income.

After the recognition of an OTTI, we account for the debt security as if it had been purchased on the measurement date of the OTTI, with an amortized cost basis equal to the previous amortized cost basis less the OTTI recognized in earnings.

We have a security monitoring process overseen by our Investment Committee, consisting of investment and accounting professionals who identify securities that, due to specified characteristics, as described below, we are subject to an enhanced analysis on a quarterly basis. We review our fixed maturity securities at least quarterly to determine if an other-than-temporary impairment is present based on specified quantitative and qualitative factors. The primary factors that we consider in evaluating whether a decline in value is other- than-temporary are:

- the length of time and the extent to which the fair value has been or is expected to be less than cost or amortized cost;

- the financial condition, credit rating and near-term prospects of the issuer;

- whether the debtor is current on contractually obligated interest and principal payments; and

- our intent and ability to retain the investment for a period of time sufficient to allow for recovery.

Each quarter, during this analysis, we assert our intent and ability to retain until recovery those securities we judge to be temporarily impaired. Once identified, we restrict trading on these securities unless subsequent information becomes available which would then alter our intent or ability to hold. The principal criteria are the deterioration in the issuer's creditworthiness, a change in regulatory requirements or a major business combination or major disposition.

Medicare Overview

Medicare is a federal program that provides eligible persons age 65 and over and certain eligible persons with disabilities under age 65 with a variety of hospital, prescription drug, and medical insurance benefits. The Medicare program consists of four parts, labeled Parts A - D.

Part A—Hospitalization benefits are provided under Part A. These benefits are financed largely through Social Security taxes. Members are not required to pay any premium for Part A benefits. However, they are still required to pay out-of-pocket deductibles and coinsurance.

Part B—Benefits for medically necessary services and supplies including outpatient care, doctor's services, physical or occupational therapists and additional home healthcare are provided under Part B. These benefits are financed through premiums paid to the federal government by those eligible members who choose to enroll in the program. The members are also required to pay out-of-pocket deductibles and coinsurance.

Part C—Under the Medicare Advantage program, private plans provide Medicare-covered healthcare benefits to enrollees and can include prescription drug coverage. Part C benefits, which include Part A and Part B, are provided through private Medicare Advantage plans.

Part D—Under Part D, prescription drug benefits may be provided by private Plans to individuals eligible for benefits under Part A and/or enrolled in Part B. These benefits are provided on both a stand-alone basis and also in connection with certain Medicare Advantage plans.

These programs are administered by CMS. These benefits are provided through HMO, PPO, PFFS and stand-alone Part D Plans in exchange for contractual risk-adjusted payments received from CMS. We contract with CMS under the Medicare program to provide a comprehensive array of health insurance and prescription drug benefits to Medicare eligible persons through our Medicare Advantage plans.

Membership—We analyze the membership for our Medicare Advantage plans (collectively, the "Plans") in our administrative system and reconcile to the enrollment provided by CMS. There are timing differences between the addition of a member to our administrative system and the approval, or accretion, of the member by CMS. Additionally, the monthly payments from CMS include adjustments to reflect changes in the status of membership as a result of retroactive terminations, additions, whether CMS is secondary to other insurance coverage or other changes. Current period membership, net premium, CMS subsidies and claims expense are adjusted to reflect retroactive changes in membership.

Premiums—Premiums received pursuant to Medicare contracts with CMS are recorded as revenue in the month in which members are entitled to receive benefits. Premiums collected in advance are deferred. Receivables from CMS and Plan members are recorded net of estimated uncollectible amounts and are reported as due and unpaid premiums in the consolidated balance sheets. We routinely monitor the collectability of specific accounts, the aging of member premium receivables, historical retroactivity trends and prevailing and anticipated economic conditions.

Medicare Risk Adjustment Provisions—CMS uses risk-adjusted rates per member to determine the monthly payments to Medicare plans. CMS has implemented a risk adjustment model which apportions premiums paid to all health Plans according to health diagnoses. The risk adjustment model uses health status indicators, or risk scores, to improve the accuracy of payment. The CMS risk adjustment model pays more for members with increasing health severity. Under this risk adjustment methodology, diagnosis data from inpatient and ambulatory treatment settings are used by CMS to calculate the risk adjusted premium payment to Medicare Plans. The monthly risk-adjusted premium per member is determined by CMS based on normalized risk scores of each member from the prior year. Annually, CMS provides the updated risk scores to the Plans and revises premium rates prospectively, beginning with the July remittance for current Plan year members. CMS will also calculate the retroactive adjustments to premium related to the revised risk scores for the current year for current Plan year members and for the prior year for prior Plan year members.

Recognition of Premium Revenues and Policy Benefits—Medicare Plans. We receive monthly payments from CMS related to members in our Medicare coordinated care Plans. The recognition of the premium and cost reimbursement components under these Plans is described below:

CMS Direct Premium Subsidy—We receive a monthly premium from CMS based on the Plan year bid we submitted to CMS. The monthly payment is a risk-adjusted amount per member and is based upon the member's risk score status, as determined by CMS. The CMS premium is recognized over the contract period and reported as premium revenue. In addition, under Medicare Secondary Payer, or MSP provisions, the premium will be reduced by CMS if CMS has determined that it is secondary to

other insurance coverage. Star rating quality bonus revenues are included in the CMS Direct Premium subsidy which is reported as premium revenue and recognized over the contract period.

Revenue Adjustments—The monthly CMS Direct Premium Subsidy is based upon the members' health status, which is determined by CMS, as more fully described above under "Medicare Risk Adjustment Provisions." All health benefit organizations that contract with CMS must capture, collect, and submit the necessary diagnosis code information to CMS within prescribed deadlines. Accordingly, we collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines for our Plans. We estimate changes in CMS premiums related to revenue adjustments based upon the diagnosis data submitted to CMS and ultimately accepted by CMS. Risk scores are updated annually by CMS and reconciled to our estimated amounts by us with any adjustments recorded in premium revenue. Although such adjustments have not been considered to be material in the past, future adjustments could be material. Effective January 1, 2016, we changed the way we estimate changes in risk adjusted premiums receivable from CMS, based on health diagnoses for our Medicare Advantage business. See Note 2—Basis of Presentation for additional information.

Member Premium—We receive a monthly premium from members based on the Plan year bid we submitted to CMS. The member premium, which is fixed for the entire Plan year, is recognized over the contract period and reported as premium revenue. We establish a reserve for member premium that is past due that reflects our estimate of the collectability of the member premium.

Low-Income Premium Subsidy—For qualifying low-income status, or LIS, members of our Plans with Part D benefits, CMS pays us for some or all of the LIS member's monthly premium. The CMS payment is dependent upon a member's income level which is determined by the Social Security Administration. Low-income premium is recognized over the contract period and reported as premium revenue.

Low-Income Cost Sharing Subsidy—For qualifying LIS members of our Plans with Part D benefits, CMS will reimburse the Plans for all or a portion of the LIS member's deductible, coinsurance and co-payment amounts above the out of pocket threshold for low income beneficiaries. Low-income cost sharing subsidies are paid by CMS prospectively as a fixed amount per member per month, and are determined based upon the Plan year bid we submitted to CMS. After the close of the annual Plan year, CMS reconciles actual experience to low-income cost sharing subsidies paid to the Plan and any differences are settled between CMS and the Plan. The low-income subsidy is accounted for as deposit accounting and therefore not recognized in operations.

Coverage Gap Discount Program—We receive advance payments from CMS as subsidies for members of our Plans with Part D coverage who reach the coverage gap. The Medicare Coverage Gap Discount Program, or CGDP, makes manufacturer discounts available to eligible Medicare members receiving applicable, covered Part D drugs, while in the coverage gap. In general, the discount on each applicable covered Part D drug is fifty percent of an amount equal to the negotiated price. Members will continue to receive these discounts and they will grow until the coverage gap is closed in 2020.

CGDP subsidies are paid by CMS as a fixed amount per member per month, and are determined based upon the Plan year bid we submitted to CMS. The subsidies made to Part D sponsors will be taken back equal to the amount of discounts invoiced to manufacturers. Manufacturers must pay the invoiced amounts to Part D sponsors within 15 days of receipt of invoice from CMS to offset the recouped amounts by CMS.

After the close of the annual Plan year, CMS reconciles the discount program subsidy payments to the cost based on the actual manufacturer discounts amounts made available to each Part D plan's enrollees under the Discount Program. The CGDP subsidy is accounted for as deposit accounting and therefore not recognized in operations.

Catastrophic Reinsurance—We receive payments from CMS for catastrophic reinsurance for members of our Plans with Part D benefits.

For the members of our HMO and PPO Plans with Part D benefits, CMS reimburses Plans for 80% of the drug costs after a member reaches his or her out of pocket catastrophic threshold through a catastrophic reinsurance subsidy. Catastrophic reinsurance subsidies are paid by CMS prospectively as a fixed amount per member per month, and are determined based upon the Plan year bid we submitted to CMS. After the close of the annual Plan year, CMS reconciles actual experience compared to catastrophic reinsurance subsidies paid to the Plan and any differences are settled between CMS and the Plan. The catastrophic reinsurance subsidy is accounted for as deposit accounting and therefore not recognized in operations.

For members of our PFFS Plans with Part D benefits, CMS makes prospective monthly catastrophic reinsurance payments to the Plans based on estimated average reinsurance payments to other Medicare Advantage—Prescription Drug (MA-PD) Plans that provide Part D benefits. Based upon the current guidelines from CMS, these Plans are at risk for the variance between their actual expense and the CMS payments. As a result, we do not follow deposit accounting for these payments.

CMS Risk Corridor Provisions for the Part D benefits of our HMO and PPO Plans —Premiums from CMS for members of our HMO and PPO Plans with Part D benefits are subject to risk corridor provisions. The CMS risk corridor calculation compares the target amount of prescription drug costs (limited to costs under the standard coverage as defined by CMS) less rebates in our annual Plan bid (target amount) to actual experience. Variances of more than 5% above the target amount will result in CMS making additional payments to us, and variances of more than 5% below the target amount will require us to refund to CMS a portion of the premiums we received. Risk corridor payments due to or from CMS are estimated throughout the year and are recognized as adjustments to premium revenues and due and unpaid premiums. This estimate requires us to consider factors that may not be certain, including: membership, risk scores, prescription drug events, or PDEs, and rebates. After the close of the annual Plan year, CMS reconciles actual experience to the target amount and any differences are settled between CMS and the Plan.

Claims—Policy and contract claims include actual claims reported but not paid and estimates of healthcare services and prescription drug claims incurred but not reported. The estimated claims incurred but not reported are based upon current enrollment, historical claim receipt and payment patterns, historical medical cost trends and health service utilization statistics. These estimates and assumptions are derived from and are continually evaluated using per member per month trend analysis, claims trends developed from our historical experience in the preceding month (adjusted for known changes in estimates of recent hospital and drug utilization data), provider contracting changes, benefit level changes, product mix and seasonality. These estimates are based on information available at the time the estimates are made, as well as anticipated future events. Actual results could differ materially from these estimates. We periodically evaluate our estimates, and as additional information becomes available or actual amounts become determinable, we may revise the recorded estimates and reflect them in operating results.

Stipulated minimum MLRs—Beginning in 2014, the ACA stipulates MLR of 85% for Medicare Advantage plans. This MLR, which is calculated at a plan level, takes into account benefit costs, quality initiative expenses, the ACA fee and taxes. Financial and other penalties may result from failing to achieve the minimum MLR ratio. For the years ended December 31, 2016, 2015 and 2014 our Medicare Advantage plans exceeded the minimum MLR, as defined by CMS.

Income Taxes

We use the liability method of accounting for income taxes. Under this method, we recognize deferred tax assets and liabilities for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. We measure deferred tax assets and liabilities using enacted tax rates that we expect to apply to taxable income in the years in which we expect those temporary differences to be recovered or settled. We recognize the effect on deferred tax assets and liabilities of a change in tax rates in income in the period that includes the enactment date of a change in tax rates.

We establish valuation allowances on our deferred tax assets for amounts that we determine will not be recoverable based upon our analysis of projected taxable income and our ability to implement prudent and feasible tax planning strategies. We recognize increases in these valuation allowances as deferred tax expense. We reflect portions of the valuation allowances subsequently determined to be no longer necessary as deferred tax benefits.

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

We establish valuation allowances based on the consideration of both positive and negative evidence. We weigh such evidence through an analysis of future reversals of existing taxable temporary differences, future taxable income exclusive of reversing temporary differences and carryforwards, taxable income in prior carryback years, and our ability to implement prudent and feasible tax planning strategies.

In accordance with ASC Topic 740-10, *Income Taxes* (ASC 740), a valuation allowance is deemed necessary when, based on the weight of all the available evidence, it is more likely than not (a likelihood of more than 50%) that some portion or all of a deferred tax asset will not be realized. The future realization of the tax benefit depends on the existence of sufficient taxable income within the carryback and carryforward periods.

In our consideration of all the available evidence, we provided more weight to evidence that was more objectively verifiable. In 2016, significant weight was given to our cumulative income/loss position. Our cumulative loss position at December 31, 2016 was due in large part to losses in our APS Healthcare businesses that were sold during 2015 and are reported in discontinued operations, the fair value adjustment and ultimate sale of our Traditional Insurance business that is reported in discontinued operations, the cumulative losses on our ACO business which include startup costs and a time lag in the recognition of revenue, the recognition of significant legal/settlement costs related to our non-core businesses and significant non-deductible expenses, particularly the ACA fee. While the Company is in a cumulative net loss position over the last three years from a financial reporting perspective, the Company has cumulative pre-tax income over the same period, after these adjustments are made.

We believe that the negative evidence of our cumulative loss is not indicative of future projected income or our ability to realize the deferred tax assets existing as of December 31, 2016. The remaining deferred tax assets, for which a valuation allowance was not established, relate to amounts that can be realized through future reversals of existing taxable temporary differences, prudent and feasible tax planning strategies and the Company's estimates of future taxable income. Any 2016 U.S. tax losses in our consolidated income tax return can be carried back to 2014 for ordinary losses and 2013 for capital losses subject to certain limitations.

Federal Income Taxation of the Company

For the year ended December 31, 2016, we will file a consolidated federal income tax return that includes most corporate subsidiaries but excludes any subsidiary that qualifies as a life insurance company or is taxed as a partnership under the Internal Revenue Code Subsidiaries that qualify as life insurance companies and partnerships will file separate federal income tax returns. We will include the taxable income or loss from a subsidiary taxed as a partnership in the tax return of its corporate owner.

We carried valuation allowances for our continuing and discontinued operations on our deferred tax assets of $20.3 million at December 31, 2016 and, $36.9 million at December 31, 2015, primarily related to foreign tax credit carryforwards that were created from the sale of our Puerto Rico subsidiaries and those we acquired in connection with our purchase of APS Healthcare in 2012, state net operating loss carryforwards, deferred income tax assets for various states and the deferred tax asset generated by the capital loss on the sale of the Traditional Insurance business.

Prior to the sale of our Traditional Insurance business, some of our U.S. insurance company subsidiaries were taxed as life insurance companies as provided in the Internal Revenue Code. The Omnibus Budget Reconciliation Act of 1990 amended the Internal Revenue Code to require a portion of the expenses incurred in selling insurance products be capitalized and amortized over a period of years, as opposed to an immediate deduction in the year incurred. Instead of measuring actual selling expenses, the amount capitalized for tax purposes is based on a percentage of premiums. In general, the capitalized amounts are subject to amortization over a ten-year period. Since this change only affects the timing of the deductions, it does not, assuming stability of income tax rates, affect the provisions for taxes reflected in our financial statements prepared in accordance with GAAP. However, by deferring deductions, the change has the effect of increasing our current tax expense and reducing statutory surplus.

At December 31, 2016, we had no unrecognized tax benefits. During 2016, we determined that certain unrecognized benefits of $0.3 previously considered potentially realizable would not be realized. During the year ended December 31, 2016, we did not recognize any refund claims. During the years ended December 31, 2015 and 2014, we recognized less than $0.1 million and $0.7 million, respectively, of refund claims filed in 2010.

We recognize interest and penalties related to unrecognized tax benefits in federal and state tax expense. During the years ended December 31, 2016, 2015 and 2014, we recognized no such interest expense and penalties.

Effects of Recently Issued and Pending Accounting Pronouncements

A summary of recent and pending accounting pronouncements is provided in Note 4—Recent and Pending Accounting Pronouncements in the Notes to Consolidated Financial Statements in our Annual Report on Form 10-K.

ITEM 7A—QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

In general, market risk to which we are subject relates to changes in interest rates that affect the market prices of our fixed income securities as well as the cost of our variable rate debt.

Investment Interest Rate Sensitivity

Our profitability could be affected if we were required to liquidate fixed income securities during periods of rising and/or volatile interest rates. We attempt to mitigate our exposure to adverse interest rate movements through a combination of active portfolio management, the use of interest rate derivatives and by staggering the maturities of our fixed income investments to assure sufficient liquidity to meet our obligations and to address reinvestment risk considerations. Our investment policy

is to balance our portfolio duration to achieve investment returns consistent with the preservation of capital and to meet payment obligations of policy benefits and claims.

Some classes of mortgage-backed securities are subject to significant prepayment risk. In periods of declining interest rates, individuals may refinance higher rate mortgages to take advantage of the lower rates then available. We monitor and adjust our investment portfolio mix to mitigate this risk.

We regularly conduct various analyses to gauge the financial impact of changes in interest rate on our financial condition. The ranges selected in these analyses reflect our assessment as being reasonably possible over the succeeding twelve-month period. The magnitude of changes modeled in the accompanying analyses should not be construed as a prediction of future economic events, but rather, be treated as a simple illustration of the potential impact of such events on our financial results.

The sensitivity analysis of interest rate risk assumes an instantaneous shift in a parallel fashion across the yield curve, with scenarios of interest rates increasing and decreasing 100 and 200 basis points from their levels as of December 31, 2016, and with all other variables held constant. The following table summarizes the impact of the assumed changes in market interest rates at December 31, 2016. Due to the current low interest rate environment, when estimating the effect of market interest rate decreases on fair value we have set an interest rate floor of 0% and have not allowed interest rates to go negative.

December 31, 2016	Effect of Change in Market Interest Rates on Fair Value of Fixed Income Portfolio as of December 31, 2016			
Fair Value of Fixed Income Portfolio	200 Basis Point Decrease	100 Basis Point Decrease	100 Basis Point Increase	200 Basis Point Increase
	(in millions)			
$ 245.2	$ 19.7	$ 10.4	$ (10.2)	$ (19.9)

ITEM 8—FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The financial statements and supplementary schedules are listed in the accompanying Index to Consolidated Financial Statements and Financial Statement Schedules in this Annual Report on Form 10-K on Page F-1.

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

None.

ITEM 9A—CONTROLS AND PROCEDURES

Disclosure Controls and Procedures

We maintain disclosure controls and procedures that are designed to ensure that we record, process, summarize and report the information required to be disclosed in the reports that we file or submit under the Securities Exchange Act of 1934 within the time periods specified in the SEC's rules and forms, and that we accumulate this information and communicate it to management, including our Chief Executive Officer, Chief Financial Officer and Chief Accounting Officer, as appropriate, to allow timely decisions regarding required disclosures.

Inherent Limitations on Effectiveness of Controls

Our disclosure controls and procedures and our internal controls over financial reporting may not prevent or detect all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. The design of a control system must reflect the fact that there are resource constraints, and we must

consider the benefits of controls relative to their costs. Further, because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that we have detected all control issues and instances of fraud, if any, within Universal American. These inherent limitations include the realities that judgments in decision making can be faulty and that breakdowns can occur because of simple error or mistake. The individual acts of some persons or collusion of two or more people can also circumvent controls. The design of any system of controls is based in part on certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions. Projections of any evaluation of the effectiveness of controls to future periods are subject to risks. Over time, controls may become inadequate because of changes in conditions or deterioration in the degree of compliance with policies or procedures.

Evaluation of Effectiveness of Controls

We carried out an evaluation under the supervision and with the participation of our management, including our Chief Executive Officer, Chief Financial Officer and Chief Accounting Officer of the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2016. Based on this evaluation, our Chief Executive Officer, Chief Financial Officer and Chief Accounting Officer concluded that our disclosure controls and procedures were effective as of December 31, 2016, at a reasonable assurance level, to timely alert management to material information required to be included in our periodic filings with the Securities and Exchange Commission.

Management's Annual Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting (as defined in Rule 13a-15(f) under the Exchange Act). A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles in the United States.

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

Management assessed our internal control over financial reporting as of December 31, 2016, the end of our fiscal year. Management based its assessment on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Based on our assessment, we determined that, as of December 31, 2016, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2016 has been audited by Deloitte & Touche LLP, an independent registered public accounting firm, as stated in their report which is included on page F-3 of our consolidated financial statements included in this Annual Report on Form 10-K.

Changes in Internal Control Over Financial Reporting

There were no changes in our internal controls over financial reporting during the quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

ITEM 9B—OTHER INFORMATION

None.

PART III

ITEM 10—DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by Item 10 is incorporated into Part III of this Annual Report on Form 10-K by reference to our definitive Proxy Statement for the Annual Meeting of Stockholders which is expected to be held on May 24, 2017, unless the Sale Transaction closes prior to such date, in which case such Annual Meeting will not be held.

ITEM 11—EXECUTIVE COMPENSATION

The information required by Item 11 is incorporated into Part III of this Annual Report on Form 10-K by reference to our definitive Proxy Statement for the Annual Meeting of Stockholders which is expected to be held on May 24, 2017, unless the Sale Transaction closes prior to such date, in which case such Annual Meeting will not be held.

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

The information required by Item 12 is incorporated into Part III of this Annual Report on Form 10-K by reference to our definitive Proxy Statement for the Annual Meeting of Stockholders which is expected to be held on May 24, 2017, unless the Sale Transaction closes prior to such date, in which case such Annual Meeting will not be held.

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

The information required by Item 13 is incorporated into Part III of this Annual Report on Form 10-K by reference to our definitive Proxy Statement for the Annual Meeting of Stockholders which is expected to be held on May 24, 2017, unless the Sale Transaction closes prior to such date, in which case such Annual Meeting will not be held.

ITEM 14—PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 14 is incorporated into Part III of this Annual Report on Form 10-K by reference to our definitive Proxy Statement for the Annual Meeting of Stockholders which is expected to be held on May 24, 2017, unless the Sale Transaction closes prior to such date, in which case such Annual Meeting will not be held.

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PART IV

ITEM 15(a)—EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

1 Financial Statements

2 Financial Statement Schedules

3 Exhibits

Exhibits

2.1 Stock Purchase and Sale Agreement, dated as of October 8, 2015, by and among NSRE Holdings Inc., a Delaware corporation, Universal American Corp., Universal American Holdings, LLC, and Nassau Reinsurance Group Holdings, L.P. (filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed with the Commission on October 14, 2015, and incorporated by reference herein).

2.2 Agreement and Plan of Merger, dated November 17, 2016, by and among Universal American Corp., WellCare Health Plans, Inc. and Wind Merger Sub, Inc. (filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed with the Commission on November 21, 2016, and incorporated by reference herein).

3.1 Amended and Restated Certificate of Incorporation of the Company (filed as Exhibit 3.1 to the Company's Current Report on Form 8-K filed with the Commission on May 4, 2011, and incorporated by reference herein).

3.2 Amended and Restated By-Laws of the Company (filed as Exhibit 3.2 to the Company's Current Report on Form 8-K filed with the Commission on May 4, 2011, and incorporated by reference herein).

3.3 First Amendment to the Amended and Restated Bylaws of Universal American Corp., effective November 17, 2016 (filed as Exhibit 3.2 to the Company's Current Report on Form 8-K filed

with the Commission on November 17, 2016, and incorporated by reference herein).

4.1 Certificate of Designation of the Series A Mandatorily Redeemable Preferred Shares (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed on March 4, 2011, and incorporated by reference herein).

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Exhibits

4.2	Certificate of Amendment to Certificate of Designation of the Series A Mandatorily Redeemable Preferred Shares (filed as Exhibit 4.1.2 to the Company's Registration Statement on Form S-4 filed on August 2, 2011, and incorporated by reference herein).
4.3	Indenture dated as of June 27, 2016 between Universal American Corp., as issuer, and U.S. Bank National Association, as trustee (filed as Exhibit 3.5 to the Company's Quarterly Report on Form 10-Q filed on August 4, 2016 and incorporated by reference herein).
10.1	Employment Agreement dated July 30, 1999, between Old Universal American and Richard A. Barasch (filed as Exhibit D to Old Universal American's Current Report on Form 8-K/A dated March 14, 2001, and incorporated by reference herein).
10.2	Employment Agreement dated March 1, 2016 by and between Universal American Corp. and Adam C. Thackery (filed as Exhibit 10.2 to the Company's Annual Report on Form 10-K filed on March 10, 2016 and incorporated by reference herein).
10.3	Employment Agreement dated July 8, 2010 by and between Universal American Corp. and Anthony Wolk (filed as Exhibit 10.4 to the Company's Annual Report on Form 10-K filed on March 6, 2013 and incorporated by reference herein).
10.4	Employment Agreement dated March 4, 2013 by and between Universal American Corp. and Erin Page (filed as Exhibit 10.5 to the Company's Annual Report on Form 10-K/A filed on March 31, 2015 and incorporated by reference herein).
10.5	Employment Agreement dated September 27, 2012 by and between Universal American Corp. and Steven H. Black (filed as Exhibit 10.6 to the Company's Annual Report on Form 10-K/A filed on March 31, 2015 and incorporated by reference herein).
10.6	Universal American Corp. 2011 Omnibus Equity Award Plan (filed as Exhibit 10.2 to the Company's Amendment No. 1 to the Registration Statement on Form S-4 filed on March 31, 2011, and incorporated by reference herein).
10.7	Form of Universal American Corp. 2011 Omnibus Equity Award Plan Employee Nonqualified Option Award Agreement (filed as Exhibit 10.4 to the Company's Registration Statement on Form S-4 filed on July 15, 2011, and incorporated by reference herein).
10.8	Form of Universal American Corp. 2011 Omnibus Equity Award Plan Employee Restricted Stock Award Agreement (filed as Exhibit 10.9 to the Company's Annual Report on Form 10-K/A filed on March 31, 2015 and incorporated by reference herein).
10.9	Form of Universal American Corp. 2011 Omnibus Equity Award Plan Employee Restricted Stock Award Agreement (filed as Exhibit 10.9 to the Company's Annual Report on Form 10-K filed on March 10, 2016 and incorporated by reference herein).

Exhibits

10.10	Form of Universal American Corp. 2011 Omnibus Equity Award Plan Employee Nonqualified Option Award Agreement (filed as Exhibit 10.10 to the Company's Annual Report on Form 10-K filed on March 10, 2016 and incorporated by reference herein).
10.11	Form of Universal American Corp. 2011 Omnibus Equity Award Plan Employee Restricted Stock Award Agreement (filed as Exhibit 10.11 to the Company's Annual Report on Form 10-K filed on March 10, 2016 and incorporated by reference herein).
12.1*	Computation of Ratio of Earnings to Fixed Charges.
21.1*	List of Subsidiaries.
23.1*	Consent of Deloitte & Touche LLP.
23.2*	Consent of Ernst & Young LLP
31.1*	Certification of Chief Executive Officer, as required by Rule 13a-14(a) of the Securities Exchange Act of 1934.
31.2*	Certification of Chief Financial Officer, as required by Rule 13a-14 (a) of the Securities Exchange Act of 1934.
31.3*	Certification of Chief Accounting Officer, as required by Rule 13a 14(a) of the Securities Exchange Act of 1934.
32.1*	Certification of the Chief Executive Officer, Chief Financial Officer and Chief Accounting Officer, as required by Rule 13a-14 (b) of the Securities Exchange Act of 1934 and 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS—XBRL	Instance Document.
101.SCH—XBRL	Taxonomy Extension Schema Document.
101.CAL—XBRL	Taxonomy Extension Calculation Linkbase Document.
101.LAB—XBRL	Taxonomy Extension Label Linkbase Document.
101.PRE—XBRL	Taxonomy Extension Presentation Linkbase Document.
101.DEF—XBRL	Taxonomy Extension Definition Linkbase Document.

* Filed or furnished herewith.

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SIGNATURES

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

UNIVERSAL AMERICAN CORP.

February 28 2017

/s/ RICHARD A. BARASCH

Richard A. Barasch
Chairman of the Board and Chief Executive Officer

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

Signature	Title	Date
/s/ RICHARD A. BARASCH Richard A. Barasch	Chairman of the Board, Chief Executive Officer and Director (Principal Executive Officer)	February 28, 2017
/s/ ADAM C. THACKERY Adam C. Thackery	Chief Financial Officer	February 28, 2017
/s/ DAVID R. MONROE David R. Monroe	Chief Accounting Officer	February 28, 2017
/s/ SALLY W. CRAWFORD Sally W. Crawford	Director	February 28, 2017
/s/ MATTHEW W. ETHERIDGE Matthew W. Etheridge	Director	February 28, 2017
/s/ MARK K. GORMLEY Mark K. Gormley	Director	February 28, 2017
/s/ MOHIT KAUSHAL Mohit Kaushal	Director	February 28, 2017
/s/ PATRICK J. MCLAUGHLIN Patrick J. McLaughlin	Director	February 28, 2017

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES
INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

Other schedules were omitted because they were not applicable.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of
Universal American Corp.

We have audited the accompanying consolidated balance sheets of Universal American Corp. and subsidiaries (the "Company") as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive loss, stockholders' equity, and cash flows for the years then ended. Our audits also included the financial statement schedules listed in the Index at Item 15(a). These financial statements and financial statement schedules are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and financial statement schedules based on our audits. The consolidated financial statements of the Company for the year ended December 31, 2014, before the effects of the retrospective adjustments for discontinued operations discussed in Note 21 to the consolidated financial statements, were audited by other auditors whose report, dated March 30, 2015, expressed an unqualified opinion on those statements and included an explanatory paragraph concerning these retrospective adjustments for discontinued operations discussed in Note 21 to the consolidated financial statements.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such 2016 and 2015 consolidated financial statements present fairly, in all material respects, the financial position of Universal America Corp. and subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

We also have audited the retrospective adjustments to the 2015 and 2014 consolidated financial statements for the operations discontinued in 2016 and 2015, as discussed in Note 21 to the consolidated financial statements. Our procedures included (1) obtaining the Company's underlying accounting analysis prepared by management of the retrospective adjustments for discontinued operations and comparing the retrospectively adjusted amounts per the 2015 and 2014 consolidated financial statements to such analysis, (2) comparing previously reported amounts to the previously issued consolidated financial statements for such years, (3) testing the mathematical accuracy of the accounting analysis, and (4) on a test basis, comparing the adjustments to retrospectively adjust the financial statements for discontinued operations to the Company's supporting documentation. In our opinion, such retrospective adjustments are appropriate and have been properly applied. However, we were not engaged to audit, review, or apply any procedures to the 2014 consolidated financial statements of the Company other than with respect to the retrospective adjustments and, accordingly, we do not express an opinion or any other form of assurance on the 2014 consolidated financial statements taken as a whole.

As discussed in Note 1 to the consolidated financial statements, on November 17, 2016, WellCare Health Plans, Inc. ("WellCare") and the Company announced a definitive agreement under which WellCare will acquire the Company. On February 16, 2017, the Company's shareholders approved the transaction. The transaction is subject to the receipt of regulatory approvals and the satisfaction of other customary closing conditions.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2016, based on the criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 28, 2017 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche LLP

New York, New York
February 28, 2017

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of Universal American Corp.

We have audited, before the effects of the retrospective adjustments for discontinued operations discussed in Note 21 to the consolidated financial statements, the accompanying consolidated statements of operations, comprehensive loss, stockholders' equity and cash flows of Universal American Corp. and subsidiaries for the year ended December 31, 2014 (the 2014 consolidated financial statements, before the effects of the retrospective adjustments discussed in Note 21 to the consolidated financial statements are not presented herein). Our audit also included, before the effects of the retrospective adjustments for the discontinued operations discussed in Note 21 to the consolidated financial statements, the financial statement schedules listed in the Index at Item 15(a) for the year ended December 31, 2014 (the 2014 financial statement schedules, before the effects of the retrospective adjustments discussed in Note 21 to the consolidated financial statements are not presented herein). The 2014 financial statements and schedules are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedules based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the 2014 financial statements referred to above, before the effects of the retrospective adjustments for discontinued operations discussed in Note 21 to the consolidated financial statements, present fairly, in all material respects, the consolidated results of Universal American Corp. and subsidiaries' operations and their cash flows for the year ended December 31, 2014, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related 2014 financial statement schedules, before the effects of the retrospective adjustments for the discontinued operations discussed in Note 21 to the consolidated financial statements, when considered in relation to the basic financial statements taken as a whole, present fairly in all material respects the information set forth therein.

We were not engaged to audit, review, or apply any procedures to the retrospective adjustments to the consolidated financial statements and schedules for the discontinued operations discussed in Note 21 to the consolidated financial statements and, accordingly, we do not express an opinion or any other form of assurance about whether such retrospective adjustments are appropriate and have been properly applied. Those retrospective adjustments were audited by other auditors.

/s/ Ernst & Young LLP
New York, NY
March 30, 2015

Report of Independent Registered Public Accounting Firm
on Internal Control Over Financial Reporting

The Board of Directors and Stockholders of
Universal American Corp.

We have audited the internal control over financial reporting of Universal American Corp. and subsidiaries (the "Company") as of December 31, 2016, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedules as of and for the year ended December 31, 2016 of the Company and our report dated February 28, 2017, expressed an unqualified opinion on those financial statements and financial

statement schedules and included an explanatory paragraph regarding the retrospective adjustments to the 2015 and 2014 consolidated financial statements for the operations discontinued in 2016 and 2015, as discussed in Note 21 to the consolidated financial statements, and an explanatory paragraph regarding the November 17, 2016 announcement that WellCare Health Plans, Inc. ("WellCare") and the Company entered into a definitive agreement under which WellCare will acquire the Company and the February 16, 2017 announcement that the Company's shareholders approved the transaction and the transaction is subject to receipt of regulatory approvals and the satisfaction of other customary closing conditions, as discussed in Note 1 to the consolidated financial statements.

/s/ Deloitte & Touche LLP

Go to...

New York, New York
February 28, 2017

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UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(in thousands, except share amounts)

	December 31, 2016	December 31, 2015
ASSETS		
Investments:		
Fixed maturities available for sale, at fair value (amortized cost: 2016, $246,087; 2015, $279,277)	$ 245,191	$ 281,776
Other invested assets	6,303	9,734
Total investments	251,494	291,510
Cash and cash equivalents	104,462	70,546
Accrued investment income	1,817	2,307
Reinsurance recoverables	1,092	406
Due and unpaid premiums	39,894	25,518
Goodwill and intangible assets	70,840	71,423
Deferred income tax asset	28,596	48,704
Income taxes receivable	12,845	5,885
Other healthcare receivables	19,819	34,127
Other assets	24,910	29,866
Assets of discontinued operations	229,814	1,150,570
Total assets	$ 785,583	$ 1,730,862
LIABILITIES AND STOCKHOLDERS' EQUITY		
LIABILITIES		
Policy and contract claims	$ 82,898	$ 86,976
Premiums received in advance	599	953
Convertible Senior Notes due 2021, net of fees	92,897	—
Series A mandatorily redeemable preferred shares, net of fees	39,939	39,755
Net amounts payable to discontinued operations	—	44,289
Accounts payable and other liabilities	62,075	60,455
Liabilities of discontinued operations	237,762	1,116,039
Total liabilities	516,170	1,348,467
Commitments and contingencies (Note 22)		
STOCKHOLDERS' EQUITY		
Preferred stock (Authorized: 40 million shares)	—	—
Common stock—voting (Authorized: 400 million shares; issued and outstanding: 2016, 58.9 million shares; 2015, 81.3 million shares)	589	813
Common stock—non-voting (Authorized: 60 million shares; issued and outstanding: 2015, 3.3 million shares)	—	33
Additional paid-in capital	443,838	608,804
Accumulated other comprehensive (loss) income	(387)	2,748
Retained deficit	(174,627)	(230,003)
Total stockholders' equity	269,413	382,395
Total liabilities and stockholders' equity	$ 785,583	$ 1,730,862

See notes to consolidated financial statements.

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UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS

(in thousands, except per share amounts)

	For the Years Ended December 31,		
	2016	2015	2014
Revenues:			
Net premiums	$ 1,366,716	$ 1,245,971	$ 1,394,736
Net investment income	8,594	11,957	19,588
Fee and other income	2,907	4,524	3,434
Net realized gains (losses)	1,429	38,954	(649)
Total revenues	1,379,646	1,301,406	1,417,109
Benefits, claims and expenses:			
Claims and other benefits	1,153,827	1,074,474	1,172,562
Amortization of intangible assets	933	2,110	2,600
Commissions	20,132	18,529	20,861
Interest expense	7,872	4,743	6,209
Affordable Care Act fee	21,731	25,489	22,910
Other operating costs and expenses	177,095	166,346	206,889
Total benefits, claims and expenses	1,381,590	1,291,691	1,432,031
(Loss) income before equity in earnings (losses) of unconsolidated subsidiaries	(1,944)	9,715	(14,922)
Equity in earnings (losses) of unconsolidated subsidiaries	4,998	(9,626)	(17,793)
Income (loss) from continuing operations before income taxes	3,054	89	(32,715)
Provision for (benefit from) income taxes	9,344	3,785	(6,107)
Loss from continuing operations	(6,290)	(3,696)	(26,608)
Discontinued operations:			
Income (loss) from discontinued operations before income taxes	67,663	(188,371)	(1,210)
Provision for (benefit from) income taxes	5,997	(28,098)	1,649
Income (loss) from discontinued operations	61,666	(160,273)	(2,859)
Net income (loss)	$ 55,376	$ (163,969)	$ (29,467)
Income (loss) per common share:			
Basic:			
Continuing operations	$ (0.09)	$ (0.04)	$ (0.32)
Discontinued operations	0.87	(1.95)	(0.03)
Net income (loss)	$ 0.78	$ (1.99)	$ (0.35)
Diluted:			
Continuing operations	$ (0.09)	$ (0.04)	$ (0.32)
Discontinued operations	0.87	(1.95)	(0.03)
Net income (loss)	$ 0.78	$ (1.99)	$ (0.35)
Basic and diluted weighted average shares outstanding	70,671	82,402	83,850
Dividends per share	$ —	$ 0.75	$ —

See notes to consolidated financial statements.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

(in thousands)

	For the years ended December 31,		
	2016	2015	2014
Comprehensive income (loss):			
Net income (loss)	$ 55,376	$ (163,969)	$ (29,467)
Other comprehensive (loss) income, net of income taxes:			
Unrealized (loss) gain on investments	(4,311)	(10,582)	7,108
Less: reclassification adjustment for gains included in net income (loss)	1,049	2,416	822
Change in net unrealized (loss) gain on investments	(5,360)	(12,998)	6,286
Change in long-term claim reserve adjustment	2,225	3,098	(967)
Total other comprehensive (loss) income, net of income taxes	(3,135)	(9,900)	5,319
Comprehensive income (loss)	$ 52,241	$ (173,869)	$ (24,148)

See notes to consolidated financial statements.

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UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(in thousands)

	Common		Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Deficit)	Total
	Voting	Non-Voting				
Balance at January 1, 2014	$ 855	$ 33	$ 693,329	$ 7,329	$ (36,647)	$ 664,899
Net loss	—	—	—	—	(29,467)	(29,467)
Other comprehensive income	—	—	—	5,319	—	5,319
Net issuance of common stock	9	—	4,861	—	—	4,870
Stock-based compensation	—	—	4,658	—	—	4,658
Dividends to stockholders	—	—	298	—	68	366
Share retirement	(60)	—	(36,120)	—	—	(36,180)
Balance at December 31, 2014	804	33	667,026	12,648	(66,046)	614,465
Net loss	—	—	—	—	(163,969)	(163,969)
Other comprehensive loss	—	—	—	(9,900)	—	(9,900)
Net issuance of common stock	9	—	417	—	—	426
Stock-based compensation	—	—	4,124	—	—	4,124
Dividends to stockholders	—	—	(62,763)	—	12	(62,751)
Balance at December 31, 2015	813	33	608,804	2,748	(230,003)	382,395
Net income	—	—	—	—	55,376	55,376
Other comprehensive loss	—	—	—	(3,135)	—	(3,135)
Net issuance of common stock	7	—	(928)	—	—	(921)
Stock-based compensation	—	—	2,113	—	—	2,113
Dividends to stockholders	—	—	1,661	—	—	1,661
Share buyback/cancellation	(231)	(33)	(180,657)	—	—	(180,921)
Equity component of convertible senior notes, net of deferred tax	—	—	12,845	—	—	12,845
Balance at December 31, 2016	$ 589	$ —	$ 443,838	$ (387)	$(174,627)	$ 269,413

See notes to consolidated financial statements.

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UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

(in thousands)

	For the Years Ended December 31,		
	2016	2015	2014
Operating activities:			
Net income (loss)	$ 55,376	$ (163,969)	$ (29,467)
(Income) loss from discontinued operations	(61,666)	160,273	2,859
Loss from continuing operations	(6,290)	(3,696)	(26,608)
Adjustments to reconcile net income (loss) to cash provided by (used for) operating activities:			
Deferred income taxes	14,397	(16,049)	(8,681)
Net realized gains on investments	(1,429)	(38,834)	(1,999)
Realized (gain) loss on sale of business	—	(120)	2,648
Amortization of intangible assets	933	2,110	2,600
Amortization of debt issuance costs	597	2,791	1,752
Amortization of debt discount on convertible notes	2,127	—	—
Net amortization of bond premium	1,377	1,724	2,017
Depreciation expense	2,774	3,256	4,669
Stock based compensation expense	6,788	9,300	9,213
Changes in Operating assets and liabilities:			
Policy and contract claims	(4,078)	(7,860)	(21,965)
Reinsurance recoverables	(686)	916	466
Due and unpaid/advance premiums	(14,730)	(4,011)	19,665
Net amounts payable to discontinued operations	11,025	72,314	21,090
Income taxes receivable	(6,960)	23,584	14,050
Other healthcare receivables	14,308	(1,932)	—
Other, net	1,106	(25,866)	(8,972)
Cash provided by operating activities of continuing operations	21,259	17,627	9,945
Cash (used for) provided by operating activities of discontinued operations	(14,713)	(53,672)	7,210
Cash provided by (used for) operating activities	6,546	(36,045)	17,155
Investing activities:			
Proceeds from sale, maturity, call, paydown or redemption of fixed maturity investments	80,867	139,722	134,559
Cost of fixed maturity investments acquired	(101,025)	(96,041)	(92,786)
Change in short-term investments	—	5,496	(5,496)
Proceeds of sale of cost method investments	—	36,300	—
Sale of business, net of cash sold	—	120	12,882
Purchase of fixed assets	(700)	(7,198)	(1,659)
Other investing activities	2,391	(343)	(244)
Cash (used for) provided by investing activities of continuing operations	(18,467)	78,056	47,256
Cash provided by investing activities of discontinued operations	83,651	73,160	32,493
Cash provided by investing activities	65,184	151,216	79,749
Financing activities:			
Net proceeds from issuance of common and preferred stock, net of tax effect	(2,187)	95	(994)
Share buyback/cancellation	(151,271)	—	(36,180)
Dividends paid to stockholders	861	(62,630)	(1,320)
Principal payment on loan payable	—	(103,447)	—
Proceeds from the issuance of convertible senior notes	115,000	—	—
Payment of issue costs—convertible senior notes	(4,877)	—	—
Distributions from discontinued operations	73,598	46,469	(2,217)
Cash provided by (used for) financing activities of continuing operations	31,124	(119,513)	(40,711)
Cash used for financing activities of discontinued operations	(73,598)	(46,469)	2,217
Cash used for financing activities	(42,474)	(165,982)	(38,494)
Net increase (decrease) in cash and cash equivalents	29,256	(50,811)	58,410
Less: decrease (increase) in cash and cash equivalents from discontinued operations	4,660	26,981	(41,920)
Net increase (decrease) in cash and cash equivalents from continuing operations	33,916	(23,830)	16,490
Cash and cash equivalents of continuing operations at beginning of period	70,546	94,376	77,886
Cash and cash equivalents of continuing operations at end of period	$ 104,462	$ 70,546	$ 94,376
Supplemental Cash Flow Information:			
Interest payments	$ 5,547	$ 4,748	$ 6,229
Cash paid (received) for income taxes	$ 8,352	$ (17,922)	$ (357)

See notes to consolidated financial statements.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. ORGANIZATION AND COMPANY BACKGROUND

Except as otherwise indicated, references to the "Company," "Universal American," "we," "our," and "us" are to Universal American Corp., a Delaware corporation, and its subsidiaries.

Universal American, through our family of healthcare companies, provides health benefits to people covered by Medicare. We are dedicated to working collaboratively with healthcare professionals, especially primary care physicians, in order to improve the health and well-being of those we serve and reduce healthcare costs.

Through our health plans and insurance subsidiary, we sell Medicare Coordinated Care Plan products in Texas, which we call HMOs, and sell Medicare Coordinated Care products in New York and Maine that are built around contracted networks of providers, which we call PPOs and Medicare Advantage Network private fee-for-service products, known as PFFS Plans. Our Medicare Advantage plans currently serve approximately 119,500 members, including 72,100 members in our Texas HMOs and 47,400 members in upstate New York and Maine.

Our subsidiary, Collaborative Health Systems, LLC, also known as CHS, works with physicians and other healthcare professionals to operate Accountable Care Organizations, or ACOs, under the Medicare Shared Savings Program, or MSSP and Next Generation ACO Model. We currently have sixteen MSSP ACOs in ten states previously approved for participation in the program by the Centers for Medicare & Medicaid Services, known as CMS and two Next Generation ACOs operating in Texas and Maryland/Virginia. Based on data provided by CMS, these ACOs currently include approximately 5,200 participating providers with approximately 221,800 assigned Medicare fee-for-service beneficiaries, both within and outside our current Medicare Advantage footprint. CHS provides these ACOs with care coordination, analytics and reporting, technology and other administrative capabilities to enable participating providers to deliver better care and lower healthcare costs for their Medicare fee-for-service beneficiaries. The Company provides funding to CHS to support the operating activities of CHS and the ACOs.

On November 17, 2016, we entered into a definitive agreement with WellCare Health Plans, Inc. ("WellCare") under which WellCare will acquire Universal American in an all cash transaction valued at $10.00 per share of common stock. We refer to this transaction throughout this Form 10-K as the "Sale Transaction." On December 30, 2016, the request for early termination of the waiting period under the Hart-Scott-Rodino Antitrust Improvements Act (HSR Act) was approved. In addition, on February 16, 2017, our stockholders approved the Sale Transaction. WellCare and the Company are pursuing the remaining regulatory approvals from regulatory agencies in Texas and New York. The Sale Transaction is expected to close in the second quarter of 2017, subject to the receipt of regulatory approvals and other customary closing conditions.

On August 3, 2016 we completed the sale of our Traditional Insurance business to Nassau Reinsurance Group Holdings, L.P. ("Nassau Re"). Under the terms of the agreement, Nassau Re acquired all of the shares of Constitution Life Insurance Company ("Constitution Life") and The Pyramid Life Insurance Company ("Pyramid"), as well as the Traditional Insurance business written by American Progressive Life & Health Insurance Company of New York ("Progressive") on a 100% coinsurance basis. As of December 31, 2015, we determined that our Traditional Insurance business should be classified as held for sale and reported as discontinued operations. Consequently, the related assets and liabilities were adjusted to fair value as of December 31, 2015 based on the estimated net amounts realizable upon sale and for all periods presented were classified as assets and liabilities of discontinued operations in our consolidated balance sheets. The related operating results and cash

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

1. ORGANIZATION AND COMPANY BACKGROUND (Continued)

flows are reported in discontinued operations in our consolidated financial statements. At December 31, 2016, assets of discontinued operations include reinsurance recoverables and cash and investments held in connection with the reinsurance treaty with Nassau Re and liabilities of discontinued operations include insurance reserves and claims payable and a liability to Nassau Re for funds held. See Note 21—Discontinued Operations for further details.

On August 1, 2016, we completed the sale of our subsidiary, Today's Options of New York, Inc., ("TONY") which operates the Total Care Medicaid Plan, to Molina Healthcare, Inc. ("Molina"). As of June 30, 2016, we determined that our Medicaid business should be classified as held for sale and reported as discontinued operations. Consequently, the related assets and liabilities were reclassified as assets and liabilities of discontinued operations in our consolidated balance sheets for all periods presented. The related operating results and cash flows are reported in discontinued operations in our consolidated financial statements. See Note 21—Discontinued Operations for further details.

On May 1, 2015, we sold our APS Healthcare domestic subsidiaries and we sold our APS Healthcare Puerto Rico subsidiaries on February 4, 2015 and these businesses are reported as discontinued operations. As a result, the related assets and liabilities for APS Healthcare have been reclassified as assets and liabilities of discontinued operations in our consolidated balance sheets and the related operating results and cash flows are reported in discontinued operations in our consolidated financial statements for all periods presented. See Note 21—Discontinued Operations for further details.

2. BASIS OF PRESENTATION

We have prepared the accompanying Consolidated Financial Statements in conformity with U.S. generally accepted accounting principles, known as GAAP, and consolidate the accounts of Universal American and its subsidiaries at December 31, 2016.

Intercompany transactions and balances have been eliminated.

Subsequent events have been evaluated through the date these consolidated financial statements were issued.

Unconsolidated Subsidiaries: We have entered into agreements with various healthcare providers to establish ACOs. These ACOs were generally formed as Limited Liability Companies. We own a majority interest in our ACOs but do not consolidate them because we share the power to direct the activities that most significantly impact the ACOs. Our share of the income of an ACO is generally 50% and our share of losses of an ACO is generally 100%. In the event of losses, we generally have the right to receive 100% of subsequent profits until our losses are recovered. Any remaining revenues are generally shared at 50%.

The ACOs are considered variable interest entities, known as VIEs, under GAAP as these entities do not have sufficient equity to finance their own operations without additional financial support. We assess our contractual, ownership or other interests in a VIE to determine if our interest participates in the variability the VIE was designed to absorb and pass onto variable interest holders. We perform an ongoing qualitative assessment of our variable interests in VIEs to determine whether we have a controlling financial interest and would therefore be considered the primary beneficiary of the VIE. The power to direct the activities of the ACOs that most significantly impact their performance is

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

2. BASIS OF PRESENTATION (Continued)

shared between us and the healthcare providers that we have joined with to establish the ACOs pursuant to the structure of the Management Committee of each of the ACOs. Accordingly, we have determined that we are not the primary beneficiary of the ACOs, and therefore we cannot consolidate them. We account for our participation in the ACOs using the equity method. Gains and losses from our participation in the ACOs are reported as equity in (losses) earnings of unconsolidated subsidiaries in the consolidated statements of operations. Our net investment in the ACOs is reported in other assets in the consolidated balance sheets.

Statutory Accounting Practices: For our insurance and HMO subsidiaries, GAAP differs from statutory accounting practices prescribed or permitted by regulatory authorities. The more significant differences include the following:

- Investments—fixed maturities available for sale are recorded at fair value with unrealized gains and losses reported in equity as a component of accumulated other comprehensive income under GAAP while for statutory purposes they are recorded at amortized cost based on their National Association of Insurance Commissioners, or NAIC, rating.

- Interest Maintenance Reserve, or IMR, on realized gains and losses—Under GAAP, realized gains and losses are reported in the statement of operations in the periods that the assets giving rise to the gains or losses are sold. For statutory purposes, a portion of the realized gains and losses is deferred under a formula prescribed by the NAIC, net of income taxes and amortized over the remaining period to maturity, as if the investment had not been sold. The net IMR deferral is reported as a non-admitted asset or a liability in the statutory balance sheet.

- Asset Valuation Reserve, or AVR—AVR is a valuation allowance on invested assets required on a statutory basis, determined by an NAIC-prescribed formula. AVR is not recognized for GAAP.

- Non-admitted assets—Under GAAP, assets are reflected in the balance sheets to the extent that they are not impaired. For statutory purposes, certain assets are designated as non-admitted, excluded from the balance sheets and recorded as a reduction of unassigned surplus.

- Policy reserves—For GAAP, policy reserves are calculated based on estimated expected experience or actual account balances while for statutory purposes such reserves are calculated based on statutorily-related interest and mortality assumptions.

- Reinsurance recoverables—For GAAP, policy and contract liabilities ceded to reinsurers are recorded as an asset. For statutory purposes, such amounts ceded to reinsurers are reported as reductions of the related liabilities.

Use of Estimates: The preparation of our financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Critical accounting policies require significant subjective or complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. These estimates are based on information available at the time the estimates are made, as well as anticipated future events. We periodically evaluate our estimates, and as additional information becomes available or

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

2. BASIS OF PRESENTATION (Continued)

actual amounts become determinable, we may revise the recorded estimates and reflect the revisions in our operating results. In our judgment, the accounts involving estimates and assumptions that are most critical to the preparation of our financial statements are policy related liabilities and expense recognition, goodwill and other intangible assets, investment valuation, revenue recognition and income taxes. All unamortized deferred acquisition costs, or DAC, were written off at December 31, 2015, in connection with the fair value adjustment on our Traditional Insurance business. As a result, we no longer consider accounting for DAC to be a critical accounting policy.

Reclassifications: In accordance with the provisions of Accounting Standards Codification, known as ASC, 205-20, *Presentation of Financial Statements—Discontinued Operations*, effective June 30, 2016, we determined that our Total Care business should be classified as held for sale and reported in discontinued operations. Also, effective December 31, 2015, we determined that our Traditional Insurance business should be classified as held for sale and reported in discontinued operations. Effective with the sale of the APS Healthcare domestic operations on May 1, 2015, we determined that our APS Healthcare businesses should be reported as discontinued operations. As a result, the results of operations and cash flows related to our Total Care, Traditional Insurance and APS Healthcare businesses are reported as discontinued operations for all periods presented. In addition, the related assets and liabilities have been segregated from the assets and liabilities related to our continuing operations and presented separately in our consolidated balance sheets. Unless otherwise noted, all disclosures in the notes accompanying our consolidated financial statements reflect only continuing operations. For additional information on our discontinued operations, see Note 21—Discontinued Operations.

Change in Accounting Estimate: CMS uses risk-adjusted rates per member to determine the monthly payments to Medicare Plans. CMS has implemented a risk adjustment model which apportions premiums paid to all health plans according to health diagnoses. The risk adjustment model uses health status indicators, or risk scores, to improve the accuracy of payment. The CMS risk adjustment model pays more for members with increasing health severity. Under this risk adjustment methodology, diagnosis data from inpatient and ambulatory treatment settings are used by CMS to calculate the risk adjusted premium payment to Medicare Plans. The monthly risk-adjusted premium per member is determined by CMS based on normalized risk scores of each member from the prior year. Annually, CMS provides the updated risk scores to the Plans and revises premium rates prospectively, beginning with the July remittance for current Plan year members. CMS will also calculate the retroactive adjustments to premium related to the revised risk scores for the current year for current Plan year members and for the prior year for prior Plan year members.

Effective January 1, 2016, we changed the way we estimate changes in risk-adjusted premiums receivable from CMS, based on health diagnoses for our Medicare Advantage business. Under our previous methodology, we estimated changes in CMS premiums related to revenue adjustments based upon the diagnosis data submitted to CMS and ultimately accepted by CMS. We believe this method resulted in a lag in recognizing revenue for changes in our members' medical condition that will ultimately be included in the final risk adjusted premium paid by CMS. During the first quarter of 2016, we completed the development and validation of a model that allows us to better estimate the risk-adjusted premiums that will ultimately be realized based upon our historical experience for members that have a full year of experience and members that have joined during the annual enrollment period or special election period. We believe this change serves to better reflect

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

2. BASIS OF PRESENTATION (Continued)

risk-adjusted premiums in the period in which they are earned and is considered a change in estimate under ASC 250, *Accounting Changes.* This change in estimate resulted in the accelerated recognition of $9.2 million of additional current year premium revenue, or $0.08 per share after tax, for the year ended December 31, 2016. Under our previous estimation process, this revenue would not have been recognized until the related diagnosis data was submitted to and accepted by CMS, typically in the first and second quarters of the subsequent year.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Cash Equivalents: We consider all highly liquid investments that have maturities of three months or less at the date of purchase to be cash equivalents. Cash equivalents include such items as certificates of deposit, commercial paper, and money market funds.

Investments: The Company follows Accounting Standards Codification No. 320, *Investments—Debt and Equity Securities,* known as ASC 320. ASC 320 requires that debt and equity securities be classified into one of three categories and accounted for as follows:

- Debt securities that we have the positive intent and the ability to hold to maturity are classified as "held to maturity" and reported at amortized cost;
- Debt and equity securities that are held for current resale are classified as "trading securities" and reported at fair value, with unrealized gains and losses included in earnings; and
- Debt and equity securities not classified as held to maturity or as trading securities are classified as "available for sale" and reported at fair value.

Unrealized gains and losses on available for sale securities are excluded from earnings and reported as accumulated other comprehensive income, unless the losses are determined to be other-than-temporary. This is reported net of tax, and the effect on certain Traditional Insurance liabilities in accordance with ASC 320-10-S99-2.

As of December 31, 2016 and 2015, we classified all fixed maturity securities as available for sale and carried them at fair value, with the unrealized gain or loss, net of tax, included in accumulated other comprehensive income. We carry short-term investments at cost, which approximates fair value. Other invested assets consist principally of equity securities, which we carry at fair value.

The fair value for fixed maturity securities is largely determined by third party pricing services. The typical inputs that third party pricing services use are

- reported trades;
- benchmark yields;
- issuer spreads;
- bids;
- offers; and

- estimated cash flows and prepayment speeds.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Based on the typical trading volumes and the lack of quoted market prices for fixed maturities, third party pricing services will normally derive the security prices through recent reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information as outlined above. If there are no recent reported trades, the third party pricing services may use matrix or model processes to develop a security price where they develop future cash flow expectations based upon collateral performance and discount this at an estimated market rate. Included in the pricing for mortgage-backed and asset-backed securities are estimates of the rate of future prepayments of principal over the remaining life of the securities. Such estimates are derived based on the characteristics of the underlying structure and prepayment speeds previously experienced at the interest rate levels projected for the underlying collateral. Actual prepayment experience may vary from these estimates.

We regularly evaluate the amortized cost of our investments compared to the fair value of those investments. We generally recognize impairments of securities when we consider a decline in fair value below the amortized cost basis to be other-than-temporary. The evaluation includes the intent and ability to hold the security to recovery, and it is considered on an individual security basis, not on a portfolio basis. We generally recognize impairment losses for mortgage-backed and asset-backed securities when an adverse change in the amount or timing of estimated cash flows occurs, unless the adverse change is solely a result of changes in estimated market interest rates. We also recognize impairment losses when we determine declines in fair values based on quoted prices to be other-than-temporary.

The evaluation of impairment is a quantitative and qualitative process which is subject to risks and uncertainties and is intended to determine whether we should recognize declines in the fair value of investments in current period earnings. The principal risks and uncertainties are:

- changes in general economic conditions;
- the issuer's financial condition or near term recovery prospects;
- the effects of changes in interest rates or credit spreads; and
- the recovery period.

Our accounting policy, which follows ASC 320-10-65-1, requires that we assess a decline in the value of a security below its cost or amortized cost basis to determine if the decline is other-than-temporary.

- If we intend to sell a debt security, or it is more likely than not that we will be required to sell the debt security before recovery of its amortized cost basis, we recognize an other-than-temporary-impairment, or OTTI, in earnings equal to the entire difference between the debt security's amortized cost basis and its fair value.
- If we do not intend to sell the debt security and it is not more likely than not that we will be required to sell the debt security before recovery of its amortized cost basis, but the present value of the cash flows expected to be collected is less than the amortized cost basis of the debt security (referred to as the credit loss), an OTTI is considered to have occurred. In this instance, we bifurcate the total OTTI into the amount related to the credit loss, which we recognize in earnings, with the remaining amount of the total OTTI attributed to other factors (referred to as the noncredit portion) recognized as a separate component in other comprehensive income.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

After the recognition of an OTTI, we account for the debt security as if it had been purchased on the measurement date of the OTTI, with an amortized cost basis equal to the previous amortized cost basis less the OTTI recognized in earnings.

We have a security monitoring process overseen by our Investment Committee, consisting of investment and accounting professionals who identify securities that, due to specified characteristics, as described below, we are subject to an enhanced analysis on a quarterly basis. We review our fixed maturity securities at least quarterly to determine if an other-than-temporary impairment is present based on specified quantitative and qualitative factors. The primary factors that we consider in evaluating whether a decline in value is other-than-temporary are:

- the length of time and the extent to which the fair value has been or is expected to be less than cost or amortized cost;
- the financial condition, credit rating and near-term prospects of the issuer;
- whether the debtor is current on contractually obligated interest and principal payments; and
- our intent and ability to retain the investment for a period of time sufficient to allow for recovery.

Each quarter, during this analysis, we assert our intent and ability to retain until recovery those securities we judge to be temporarily impaired. Once identified, we restrict trading on these securities unless subsequent information becomes available which would then alter our intent or ability to hold. The principal criteria are the deterioration in the issuer's creditworthiness, a change in regulatory requirements or a major business combination or major disposition.

During the years ended December 31, 2016, 2015 and 2014 we recorded no OTTI realized losses.

Realized investment gains and losses on the sale of securities are based on the specific identification method.

We generally record investment income when earned. We amortize premiums and discounts arising from the purchase of mortgage-backed and asset-backed securities into investment income over the estimated remaining term of the securities, adjusted for anticipated prepayments. We use the prospective method to account for the impact on investment income of changes in the estimated future cash flows for these securities. We amortize premiums and discounts on other fixed maturity securities using the interest method over the remaining term of the security.

Goodwill and intangible assets:

Goodwill: Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. ASC 350, *Goodwill and Other Intangible Assets*, requires that goodwill balances be reviewed for impairment at the reporting unit level at least annually or more frequently if events occur or circumstances change that would indicate that a triggering event, as defined in ASC 350, has occurred. A reporting unit is defined as an operating segment or one level below an operating segment. Our reporting units are equivalent to our operating segments. We have goodwill assigned to our Medicare Advantage reporting unit.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

We test goodwill for impairment annually, as of October 1 of the current year, or more frequently if circumstances suggest that impairment may exist. During each quarter, we perform a review of certain key components of our valuation of our reporting units, including the operating performance of the reporting units compared to plan (which is the primary basis for the prospective financial information included in our annual goodwill impairment test), our weighted average cost of capital and our stock price and market capitalization.

We estimate the fair values of our reporting units using discounted cash flows or other indications of fair value, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of cash flow (including significant assumptions about operations and target capital requirements), long term growth rates for determining terminal value, and discount rates. Forecasts and long term growth rates used for our reporting units are consistent with, and use inputs from, our internal long term business plan and strategy. During our forecasting process, we assess revenue trends, medical cost trends, operating cost levels and target capital levels. Significant factors affecting these trends include changes in membership, premium yield, medical cost trends, contract renewal expectations and the impact and expectations of regulatory environments.

Although we believe that the financial projections used are reasonable and appropriate, the use of different assumptions and estimates could materially impact the analysis and resulting conclusions. In addition, due to the long term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of healthcare reforms as discussed in Item 1, "Business—Regulation."

We use a range of discount rates that correspond to a market-based weighted average cost of capital. Discount rates are determined for each reporting unit based on the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. The most significant estimates in the discount rate determinations include the risk free rates and equity risk premium. Company specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty in regards to the reporting units' operations could cause these assumptions used in our analysis to change materially in the future. If our assumptions differ from actual, the estimates underlying our goodwill impairment tests could be adversely affected.

Future events that could have a negative impact on the levels of excess fair value over carrying value of our reporting units include, but are not limited to:

- decreases in business growth;
- decreases in forecasted margins;
- the loss of significant contracts;
- regulatory changes impacting the reporting unit;
- decreases in earnings projections;
- increases in the weighted average cost of capital; and

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

- increases in the amount of required capital for a reporting unit.

Negative changes in one or more of these factors, among others, could result in additional impairment charges.

To determine whether goodwill is impaired, we perform a multi-step impairment test. We perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if we elect to proceed directly with quantitative testing, we will measure the fair values of the reporting units and compare them to their carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, the second step of the impairment test is performed for the purposes of measuring the impairment. In this step, the fair value of the reporting unit is allocated to all of the assets and liabilities of the reporting unit to determine an implied goodwill value. This allocation is similar to a purchase price allocation performed in purchase accounting. If the carrying amount of the reporting unit goodwill exceeds the implied goodwill value, an impairment loss shall be recognized in an amount equal to that excess.

Valuation of acquired intangible assets: Business combinations accounted for as a purchase result in the allocation of the purchase consideration to the fair values of the assets and liabilities acquired, including the present value of future profits and other identified intangibles, establishing these fair values as the new accounting basis. We base the fair values on an estimate of the cash flows of the identified intangible, discounted to reflect the present value of those cash flows. The discount rate we select depends upon the general market conditions at the time of the acquisition and the inherent risk in the transaction. We allocate purchase consideration in excess of the fair value of net assets acquired, including the present value of future profits and other identified intangibles, for a specific acquisition, to goodwill. We perform the allocation of purchase price in the period in which we consummate the purchase.

Amortizing intangible assets: We must estimate and make assumptions regarding the useful life we assign to our amortizing intangible assets. Set forth below are our annual amortization policies for each of the main categories of amortizing intangible assets which have an unamortized balance at December 31, 2016. All are being amortized over the estimated weighted average life of the related asset on a straight line basis.

Description	Weighted Average Life Remaining (Years)
Membership base	6
Provider contracts	<1
Non-compete	4

In accordance with ASC 350, *Intangibles—Goodwill and Other*, we periodically review amortizing intangible assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. If these estimates or their related assumptions change in the future, we may be required to record impairment losses for these assets.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Medicare Overview: Medicare is a federal health insurance program that provides Americans age 65 and over, and some disabled persons under the age of 65, certain hospital, medical and prescription drug benefits. The Medicare program consists of four parts, labeled Parts A - D.

Part A—Hospitalization benefits are provided under Part A. These benefits are financed largely through Social Security taxes. Members are not required to pay any premium for Part A benefits. However, they are still required to pay out-of-pocket deductibles and coinsurance.

Part B—Benefits for medically necessary services and supplies including outpatient care, doctor's services, physical or occupational therapists and additional home health care are provided under Part B. These benefits are financed through premiums paid to the federal government by those eligible members who choose to enroll in the program. The members are also required to pay out-of-pocket deductibles and coinsurance.

Part C—Under the Medicare Advantage program, private plans provide Medicare-covered health care benefits to enrollees and can include prescription drug coverage. Part C benefits, which include Part A and Part B, are provided through private Medicare Advantage plans.

Part D—Under Part D, prescription drug benefits may be provided by private plans to individuals eligible for benefits under Part A and/or enrolled in Part B. These benefits are provided on both a stand-alone basis and also in connection with certain Medicare Advantage plans.

These programs are administered by CMS. These benefits are provided through HMO, PPO, PFFS and stand-alone Part D Plans in exchange for contractual risk-adjusted payments received from CMS. We contract with CMS under the Medicare program to provide a comprehensive array of health insurance and prescription drug benefits to Medicare eligible persons through our Medicare Advantage plans.

Membership—We analyze the membership for our Medicare Advantage Plans (collectively, the "Plans") in our administrative system and reconcile to the enrollment provided by CMS. There are timing differences between the addition of a member to our administrative system and the approval, or accretion, of the member by CMS. Additionally, the monthly payments from CMS include adjustments to reflect changes in the status of membership as a result of retroactive terminations, additions, whether CMS is secondary to other insurance coverage or other changes. Current period membership, net premium, CMS subsidies and claims expense are adjusted to reflect retroactive changes in membership.

Premiums—Premiums received pursuant to Medicare contracts with CMS are recorded as revenue in the month in which members are entitled to receive benefits. Premiums collected in advance are deferred. Receivables from CMS and Plan members are recorded net of estimated uncollectible amounts and are reported as due and unpaid premiums in the consolidated balance sheets. We routinely monitor the collectability of specific accounts, the aging of member premium receivables, historical retroactivity trends and prevailing and anticipated economic conditions.

Medicare Risk Adjustment Provisions—CMS uses risk-adjusted rates per member to determine the monthly payments to Medicare Plans. CMS has implemented a risk adjustment model which apportions premiums paid to all health plans according to health diagnoses. The risk adjustment model uses health status indicators, or risk scores, to improve the accuracy of payment. The CMS risk adjustment model

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

pays more for members with increasing health severity. Under this risk adjustment methodology, diagnosis data from inpatient and ambulatory treatment settings are used by CMS to calculate the risk adjusted premium payment to Medicare Plans. The monthly risk-adjusted premium per member is determined by CMS based on normalized risk scores of each member from the prior year. Annually, CMS provides the updated risk scores to the Plans and revises premium rates prospectively, beginning with the July remittance for current Plan year members. CMS will also calculate the retroactive adjustments to premium related to the revised risk scores for the current year for current Plan year members and for the prior year for prior Plan year members.

Recognition of Premium Revenues and Policy Benefits—Medicare Plans—We receive monthly payments from CMS related to members in our Medicare coordinated care Plans. The recognition of the premium and cost reimbursement components under these Plans is described below:

CMS Direct Premium Subsidy—We receive a monthly premium from CMS based on the Plan year bid we submitted to CMS. The monthly payment is a risk-adjusted amount per member and is based upon the member's risk score status, as determined by CMS. The CMS premium is recognized over the contract period and reported as premium revenue. In addition, under Medicare Secondary Payer, or MSP provisions, the premium will be reduced by CMS if CMS has determined that it is secondary to other insurance coverage. Star rating quality bonus revenues are included in the CMS Direct Premium subsidy which is reported as premium revenue and recognized over the contract period.

Revenue Adjustments—The monthly CMS Direct Premium Subsidy is based upon the members' health status, which is determined by CMS, as more fully described above under "Medicare Risk Adjustment Provisions." All health benefit organizations that contract with CMS must capture, collect, and submit the necessary diagnosis code information to CMS within prescribed deadlines. Accordingly, we collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines for our Plans. We estimate changes in CMS premiums related to revenue adjustments based upon the diagnosis data submitted to CMS and ultimately accepted by CMS. Risk scores are updated annually by CMS and reconciled to our estimated amounts by us with any adjustments recorded in premium revenue. Although such adjustments have not been considered to be material in the past, future adjustments could be material. Effective January 1, 2016, we changed the way we estimate changes in risk adjusted premiums receivable from CMS, based on health diagnoses for our Medicare Advantage business. See Note 2—Basis of Presentation for additional information.

Member Premium—On plans that have a member premium component, we bill a monthly premium to members based on the Plan year bid we submitted to CMS. The member premium, which is fixed for the entire Plan year, is recognized over the contract period and reported as premium revenue. We establish a reserve for member premium that is past due that reflects our estimate of the collectability of the member premium.

Low-Income Premium Subsidy—For qualifying low-income status, or LIS, members of our Plans with Part D benefits, CMS pays us for some or all of the LIS member's monthly pharmacy benefit premium. The CMS payment is dependent upon a member's income level which is determined by the Social Security Administration. Low-income premium is recognized over the contract period and reported as premium revenue.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Low-Income Cost Sharing Subsidy—For qualifying LIS members of our Plans with Part D benefits, CMS will reimburse the Plans for all or a portion of the LIS member's deductible, coinsurance and co-payment amounts for pharmacy benefits above the out of pocket threshold for low income beneficiaries. Low-income cost sharing subsidies are paid by CMS prospectively as a fixed amount per member per month, and are determined based upon the Plan year bid we submitted to CMS. After the close of the annual Plan year, CMS reconciles actual experience to low-income cost sharing subsidies paid to the Plan and any differences are settled between CMS and the Plan. The low-income subsidy is accounted for as deposit accounting and therefore not recognized in operations.

Coverage Gap Discount Program—We receive advance payments from CMS as subsidies for members of our Plans with Part D coverage who reach the coverage gap. The Medicare Coverage Gap Discount Program, or CGDP, makes manufacturer discounts available to eligible Medicare beneficiaries receiving applicable covered Part D drugs while in the coverage gap. In general, the discount on each applicable covered Part D drug is fifty percent of an amount equal to the negotiated price. Members will continue to receive these discounts and they will grow until the coverage gap is closed in 2020.

CGDP subsidies are paid by CMS as a fixed amount per member per month, and are determined based upon the Plan year bid we submitted to CMS. The subsidies made to Part D sponsors will be taken back equal to the amount of discounts invoiced to manufacturers. Manufacturers must pay the invoiced amounts to Part D sponsors within 15 days of receipt of invoice from CMS to offset the recouped amounts by CMS.

After the close of the annual Plan year, CMS reconciles the discount program subsidy payments to the cost based on the actual manufacturer discounts amounts made available to each Part D Plan's enrollees under the Discount Program. The CGDP subsidy is accounted for as deposit accounting and therefore not recognized in operations.

Catastrophic Reinsurance—We receive payments from CMS for catastrophic reinsurance for members of our Plans with Part D benefits.

For the members of our HMO and PPO Plans with Part D benefits, CMS reimburses Plans for 80% of the drug costs after a member reaches his or her out of pocket catastrophic threshold through a catastrophic reinsurance subsidy. Catastrophic reinsurance subsidies are paid by CMS prospectively as a fixed amount per member per month, and are determined based upon the Plan year bid we submitted to CMS. After the close of the annual Plan year, CMS reconciles actual experience compared to catastrophic reinsurance subsidies paid to the Plan and any differences are settled between CMS and the Plan. The catastrophic reinsurance subsidy is accounted for as deposit accounting and therefore not recognized in operations.

For members of our Network PFFS Plans with Part D benefits, CMS makes prospective monthly catastrophic reinsurance payments to the Plans based on estimated average reinsurance payments to other Medicare Advantage—Prescription Drug (MA-PD) Plans that provide Part D benefits. Based upon the current guidelines from CMS, these Plans are at risk for the variance between their actual expense and the CMS payments. As a result, we do not follow deposit accounting for these payments.

CMS Risk Corridor Provisions for the Part D benefits of our HMO and PPO Plans —Premiums from CMS for members of our HMO and PPO Plans with Part D benefits are subject to risk corridor provisions. The CMS risk corridor calculation compares the target amount of prescription drug costs

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

(limited to costs under the standard coverage as defined by CMS) less rebates in our annual Plan bid (target amount) to actual experience. Variances of more than 5% above the target amount will result in CMS making additional payments to us, and variances of more than 5% below the target amount will require us to refund a portion of the premiums we received to CMS. Risk corridor payments due to or from CMS are estimated throughout the year and are recognized as adjustments to premium revenues and due and unpaid premiums. This estimate requires us to consider factors that may not be certain, including: membership, risk scores, prescription drug events, or PDEs, and rebates. After the close of the annual Plan year, CMS reconciles actual experience to the target amount and any differences are settled between CMS and the Plan.

Claims—Policy and contract claims include actual claims reported but not paid and estimates of health care services and prescription drug claims incurred but not reported, known as IBNR. The estimated IBNR are based upon current enrollment, historical claim receipt and payment patterns, historical medical cost trends and health service utilization statistics. These estimates and assumptions are derived from and are continually evaluated using per member per month trend analysis, claims trends developed from our historical experience in the preceding month (adjusted for known changes in estimates of recent hospital and drug utilization data), provider contracting changes, benefit level changes, product mix and seasonality. These estimates are based on information available at the time the estimates are made, as well as anticipated future events. Actual results could differ materially from these estimates. We periodically evaluate our estimates, and as additional information becomes available or actual amounts become determinable, we may revise the recorded estimates and reflect them in operating results.

Stipulated minimum MLRs—Beginning in 2014, The Patient Protection and Affordable Care Act, or ACA, stipulates a minimum medical loss ratio, or MLR, of 85% for Medicare Advantage plans. This MLR which is calculated at a plan level, takes into account benefit costs, quality initiative expenses, the ACA fee and taxes. Financial and other penalties may result from failing to achieve the minimum MLR ratio. For the years ended December 31, 2016, 2015 and 2014 our Medicare Advantage plans exceeded the minimum MLR, as defined by CMS.

Recognition of Revenues—Accountable Care Organizations: The Medicare Shared Savings Program, or MSSP, is relatively new and therefore has limited historical experience. This impacts our ability to accurately accumulate and interpret the data available for calculating the ACOs' shared savings. Therefore, during 2016, 2015 and 2014, we recognized our portion of ACO shared savings revenue when notified by CMS. Such notification lags the Program Year to which the revenue relates by six to nine months. Revenue from the initial 2012/2013 Program Year, which ended on December 31, 2013, was recorded in the quarter ended September 30, 2014 and revenue for the 2014 Program Year, which ended on December 31, 2014, was recorded in the quarter ended June 30, 2015. Revenue for the 2015 Program Year, which ended on December 31, 2015, was recorded in the quarter ended June 30, 2016. Similarly, we were not able to recognize revenue for the year ended December 31, 2016 in the 2016 financial statements. We expect that revenue, if any, for the program year ended December 31, 2016 will be reported in 2017 when the MSSP revenue is either known or estimable with reasonable certainty. Based on the ACO operating agreements, we bear all costs of the ACO operations until revenue is recognized. At that point, we share in up to 100% of the revenue to recover our costs incurred. Any remaining revenue is generally shared equally with our ACO provider partners.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

During 2016, we operated one ACO under the new Next Generation ACO Model. This Next Generation ACO receives different beneficiary information from CMS during the year than the MSSP ACOs. During 2016, we were able to use this information to estimate Program Year 2016 revenue for this Next Generation ACO, but determined, based on the information available, that this ACO would not earn any shared savings revenue for 2016. Based on our analysis, we accrued a $1.7 million estimated loss for 2016.

Affordable Care Act Fee: The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (the Acts) imposes an annual fee on health insurers (the "ACA fee") for each calendar year beginning on or after January 1, 2014. A health insurer's portion of the annual fee is payable no later than September 30 of the applicable calendar year and is not tax deductible. The annual fee for the health insurance industry is allocated to individual health insurers based on the ratio of the amount of an entity's direct premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. ASU 2011-06, *Other Expenses, Fees Paid to the Federal Government by Health Insurers* provides that the liability for the ACA Fee should be estimated and recorded in full once the entity provides qualifying health insurance in the corresponding period with a corresponding deferred cost that is to be amortized to expense on a straight-line basis over the applicable calendar year. We record the ACA Fee liability in other liabilities and the deferred cost in other assets in the consolidated balance sheets. The related expense is recorded as ACA Fee in the consolidated statements of operations. The 2016 ACA Fee was paid in September 2016. At December 31, 2016, we had no accrued liability and the deferred asset was fully amortized. The ACA Fee has been suspended for 2017 by the Consolidated Appropriations Act, 2016 and the Protecting Americans from Tax Hikes Act of 2015.

Income Taxes: We use the liability method of accounting for income taxes. Under this method, we recognize deferred tax assets and liabilities for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. We measure deferred tax assets and liabilities using enacted tax rates that we expect to apply to taxable income in the years in which we expect those temporary differences to be recovered or settled. We recognize the effect on deferred tax assets and liabilities of a change in tax rates in income in the period that includes the enactment date of a change in tax rates.

We establish valuation allowances on our deferred tax assets for amounts that we determine will not be recoverable based upon our analysis of projected taxable income and our ability to implement prudent and feasible tax planning strategies. We recognize increases in these valuation allowances as deferred tax expense. We reflect portions of the valuation allowances subsequently determined to be no longer necessary as deferred tax benefits.

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

Reinsurance: We report amounts recoverable under reinsurance contracts in total assets as reinsurance recoverables rather than netting those amounts against the related policy asset or liability.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

We account for the cost of reinsurance related to long-duration contracts over the life of the underlying reinsured policies using assumptions consistent with those used to account for the underlying policies.

Stock-Based Compensation: We have a stock-based incentive plan for our employees, non-employee directors, agents and others. Detailed information for activity in our stock plans can be found in Note 15—Stock-Based Compensation. In accordance with ASC 718, *Compensation—Stock Compensation*, we recognize compensation costs for share-based payments to employees and non-employee directors based on the grant date fair value of the award and permits them to amortize this fair value over the grantees' service period.

We determine stock-based compensation for non-employees based on guidance contained in ASC 505-50, *Equity—Equity-Based Payments to Non-Employees*. We expense the fair value of the awards over the vesting period of each award.

Net amounts payable to discontinued operations: Amounts payable to discontinued operations represent the cash and investments related to the reinsurance of the Traditional Insurance business written by Progressive through a 100% quota share coinsurance agreement as part of the sale of our Traditional Insurance business to Nassau Re.

4. RECENTLY ISSUED AND PENDING ACCOUNTING PRONOUNCEMENTS

Statement of Cash Flows: In November 2016, the Financial Accounting Standards Board issued Accounting Standards Update ("ASU") 2016-18, Statement of Cash Flows (Topic 230)—Restricted Cash. The guidance requires that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. ASU 2016-18 does not provide a definition of restricted cash or restricted cash equivalents. ASU 2016-18 is effective for public business entities for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. Early adoption is permitted, including adoption in an interim period. If an entity early adopts the amendments in an interim period, any adjustments should be reflected as of the beginning of the fiscal year that includes that interim period. We are currently evaluating the impact of adoption on our consolidated statements of cash flows.

Statement of Cash Flows: In August 2016, the Financial Accounting Standards Board issued Accounting Standards Update ("ASU") 2016-15, Statement of Cash Flows (Topic 230)—*Classification of Certain Cash Receipts and Cash Payments.* This ASU provides guidance on classification in the statement of cash flows for eight specific cash flow reporting issues and clarifies application of the predominance principle in determining classification within the statement of cash flows, with the objective of reducing diversity in practice. ASU 2016-15 is effective for public companies for annual periods, and interim periods within those annual periods, beginning after December 15, 2017, with early adoption permitted. Retrospective application is required unless impracticable. We are currently evaluating the impact of adoption on our consolidated statements of cash flows.

Financial Instruments—Credit Losses: In June 2016, the Financial Accounting Standards Board issued Accounting Standards Update ("ASU") 2016-13, Financial Instruments—Credit Losses—*Measurements of Credit Losses on Financial Instruments.* The updated guidance applies a new credit loss model, current expected credit losses, for determining credit-related impairments for financial instruments measured at amortized cost (e.g. reinsurance recoverables) and requires an entity to

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

4. RECENTLY ISSUED AND PENDING ACCOUNTING PRONOUNCEMENTS (Continued)

estimate the credit losses expected over the life of an exposure or pool of exposures. The estimate of expected credit losses should consider historical information, current information, as well as reasonable and supportable forecasts, including estimates of prepayments. The expected credit losses, and subsequent adjustments to such losses, will be recorded through an allowance account that is deducted from the amortized cost basis of the financial asset, with the net carrying value of the financial asset presented on the consolidated balance sheet at the amount expected to be collected.

The updated guidance also amends the current other-than-temporary impairment model for available-for-sale debt securities by requiring the recognition of impairments relating to credit losses through an allowance account and limits the amount of credit loss to the difference between a security's amortized cost basis and its fair value. In addition, the length of time a security has been in an unrealized loss position will no longer impact the determination of whether a credit loss exists.

The updated guidance is effective for reporting periods beginning after December 15, 2019. Early adoption is permitted for reporting periods beginning after December 15, 2018. We are currently analyzing the impact of adoption of this statement on our financial position, results of operations and cash flows.

Revenue from Contracts with Customers—In May 2016, the Financial Accounting Standards Board issued Accounting Standards Update ("ASU") 2016-12, Revenue from Contracts with Customers—*Narrow-Scope Improvements and Practical Expedients*. This ASU does not change the core principles of Topic ASC 606, Revenue from Contracts with Customers, but makes amendments to revenue guidance on licenses of intellectual property, identifying performance obligations, collectability, noncash consideration, and the presentation of sales and other similar taxes. It also clarified the definition of a completed contract at transition and added a practical expedient to ease transition for contracts that were modified prior to adoption.

The effective date and transition requirements for the amendments in this ASU are the same as the effective date and transition requirements in Topic 606. Public entities must apply the new guidance to annual reporting periods beginning after December 15, 2017, including interim reporting periods within that reporting period. Earlier application is permitted only as of annual reporting periods beginning after December 15, 2016, including interim reporting periods within that reporting period. Early adoption prior to that date is not permitted. In addition, entities are required to adopt the ASU by using the same transition method they used to adopt the new revenue standard. That is either a full retrospective or modified retrospective approach. We are currently in the process of evaluating this new guidance, and do not expect it to have a material impact on our financial position, results of operations or cash flows.

Stock-Based Compensation: In March 2016, the Financial Accounting Standards Board issued Accounting Standards Update ("ASU") 2016-09, *Compensation—Stock Compensation—Improvements to Employee Share-Based Payment Accounting*. This ASU addresses certain aspects of share-based payments to employees including the income tax consequences, classification of awards as either equity or liabilities, and classification in the statement of cash flows. Entities will be required to recognize the income tax effects of awards in the income statement when the awards vest or are settled (e.g., additional paid-in capital or APIC pools will be eliminated). The guidance on employers' accounting for an employee's use of shares to satisfy the employer's statutory income tax withholding obligation and for forfeitures is also changing.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

4. RECENTLY ISSUED AND PENDING ACCOUNTING PRONOUNCEMENTS (Continued)

For public companies, the amendments in this ASU are effective for annual periods beginning after December 15, 2016, and interim periods within those annual periods. Early adoption is permitted, but all of the guidance must be adopted in the same period. We adopted ASU 2016-09 effective January 1, 2017. Adoption did not have a material effect on our consolidated financial statements.

5. INVESTMENTS

The amortized cost and fair value of fixed maturity investments are as follows:

	December 31, 2016			
Classification	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
	(in thousands)			
U.S. Treasury securities and U.S. Government obligations	$ 22,604	$ 8	$ (651)	$ 21,961
Government sponsored agencies	513	—	(5)	508
Other political subdivisions	25,726	191	(253)	25,664
Corporate debt securities	118,634	2,363	(2,019)	118,978
Foreign debt securities	32,006	345	(1,103)	31,248
Residential mortgage-backed securities	21,242	695	(100)	21,837
Commercial mortgage-backed securities	21,113	95	(446)	20,762
Other asset-backed securities	4,249	24	(40)	4,233
	$ 246,087	$ 3,721	$ (4,617)	$ 245,191

	December 31, 2015			
Classification	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
	(in thousands)			
U.S. Treasury securities and U.S. Government obligations	$ 8,481	$ 5	$ (8)	$ 8,478
Government sponsored agencies	516	—	(9)	507
Other political subdivisions	35,253	771	(98)	35,926
Corporate debt securities	144,772	4,076	(2,425)	146,423
Foreign debt securities	28,287	471	(1,159)	27,599
Residential mortgage-backed securities	34,973	1,254	(258)	35,969
Commercial mortgage-backed securities	21,264	68	(181)	21,151
Other asset-backed securities	5,731	33	(41)	5,723
	$ 279,277	$ 6,678	$ (4,179)	$ 281,776

At December 31, 2016, gross unrealized losses were primarily driven by corporate debt securities and foreign debt securities. The fair values of these securities are depressed primarily due to increases in market interest rates driven by increases in treasury yields versus December 31, 2015. We have evaluated these holdings with our investment managers and do not believe any individual holdings to be other-than-temporarily impaired.

The amortized cost and fair value of fixed maturity investments at December 31, 2016 by contractual maturity are shown below. Expected maturities will differ from contractual maturities

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

5. INVESTMENTS (Continued)

because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in thousands)	
Due in 1 year or less	$ 14,003	$ 14,222
Due after 1 year through 5 years	87,981	88,629
Due after 5 years through 10 years	75,470	74,925
Due after 10 years	22,029	20,583
Mortgage and asset-backed securities	46,604	46,832
	$ 246,087	$ 245,191

The fair value and unrealized loss as of December 31, 2016 and 2015 for fixed maturities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position, are shown below:

	Less than 12 Months		12 Months or Longer		Total	
December 31, 2016	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in thousands)					
U.S. Treasury securities and U.S. Government obligations	$ 20,302	$ (651)	$ —	$ —	$ 20,302	$ (651)
Government sponsored agencies	508	(5)	—	—	508	(5)
Other political subdivisions	10,229	(87)	1,414	(166)	11,643	(253)
Corporate debt securities	53,257	(1,173)	6,991	(846)	60,248	(2,019)
Foreign debt securities	16,782	(378)	5,137	(725)	21,919	(1,103)
Residential mortgage-backed securities	3,280	(83)	556	(17)	3,836	(100)
Commercial mortgage-backed securities	10,677	(442)	1,829	(4)	12,506	(446)
Other asset-backed securities	—	—	2,067	(40)	2,067	(40)
Total fixed maturities	$ 115,035	$ (2,819)	$ 17,994	$ (1,798)	$ 133,029	$ (4,617)
Total number of securities in an unrealized						

loss position 111

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

5. INVESTMENTS (Continued)

	Less than 12 Months		12 Months or Longer		Total	
December 31, 2015	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in thousands)					
U.S. Treasury securities and U.S. Government obligations	$ 5,210	$ (8)	$ —	$ —	$ 5,210	$ (8)
Government sponsored agencies	507	(9)	—	—	507	(9)
Other political subdivisions	3,162	(98)	—	—	3,162	(98)
Corporate debt securities	48,819	(2,392)	1,396	(33)	50,215	(2,425)
Foreign debt securities	6,528	(382)	5,085	(777)	11,613	(1,159)
Residential mortgage-backed securities	3,021	(41)	6,701	(217)	9,722	(258)
Commercial mortgage-backed securities	7,422	(151)	2,108	(30)	9,530	(181)
Other asset-backed securities	1,467	(22)	928	(19)	2,395	(41)
Total fixed maturities	$ 76,136	$ (3,103)	$ 16,218	$ (1,076)	$ 92,354	$ (4,179)
Total number of securities in an unrealized loss position						97

The decrease in fixed income security prices at December 31, 2016 compared to December 31, 2015, and the resulting increase in the number of securities in an unrealized loss position, is due to an increase in market interest rates primarily driven by increases in treasury yields.

Net Investment Income and Realized Gains and Losses

The details of net investment income are as follows:

	2016	2015	2014
		(in thousands)	
Investment Income:			
Fixed maturities	$ 8,424	$ 9,550	$ 15,160

Cash and cash equivalents	634	172	65
Other(1)	86	2,811	5,167
Gross investment income	9,144	12,533	20,392
Investment expenses	(550)	(576)	(804)
Net investment income	$ 8,594	$ 11,957	$ 19,588

(1) Other investment income in 2015 and 2014 includes distributions on cost-method investments of $2.0 million and $2.8 million, respectively, as well as investment income on intercompany loans made to entities included in Discontinued Operations of $0.8 million and $2.3 million, respectively.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

5. INVESTMENTS (Continued)

Gross realized gains and gross realized losses included in the consolidated statements of operations are as follows:

	2016	2015	2014
		(in thousands)	
Realized gains:			
Fixed maturities	$ 1,673	$ 4,233	$ 2,649
Realized gain on sale of equity investments(1)	—	35,705	—
Other	119	30	—
	1,792	39,968	2,649
Realized losses:			
Fixed maturities	(220)	(589)	(650)
Other	(143)	(545)	—
Net realized gains on investments	1,429	38,834	1,999
Realized gain (loss) on sale of businesses(2)	—	120	(2,648)
Net realized gains (losses)	$ 1,429	$ 38,954	$ (649)

(1) Represents a gain on the sale of our cost-method investments in naviHealth of $29.6 million and DDDS of $6.1 million in 2015.

(2) 2014 amount represents losses realized upon the sales of Today's Options of Oklahoma, or TOOK, and Select Care of Oklahoma, or SCOK. For further discussion of those transactions, see Note 20—Sales of Subsidiaries.

At December 31, 2016 and 2015, we held unrated or below-investment grade fixed maturity securities as follows:

	2016	2015
	(in thousands)	
Carrying value	$ 1,016	$ 1,029
Percentage of total investments, cash and cash equivalents	0.3%	0.3%

The largest investment in any one such below investment grade security was $1.0 million, or 0.4% of total assets at December 31, 2016 and December 31, 2015. The below investment grade holdings are comprised of one municipal security, with a fair value of $0.9 million, whose maturity has been cash collateralized causing the security to no longer require a rating and one residential MBS with a fair value of less than $0.1 million at December 31, 2016.

We had no non-income producing fixed maturity securities for the years ended December 31, 2016, 2015 and 2014.

We have reflected investments held by various states as security for our policyholders in our fixed maturity investments. These investments had carrying values of $3.9 million at both December 31, 2016 and December 31, 2015.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

6. FAIR VALUE MEASUREMENTS

We carry fixed maturity investments and equity securities at fair value in our Consolidated Financial Statements. These fair value disclosures consist of information regarding the valuation of these financial instruments followed by the fair value measurement disclosure requirements of *Fair Value Measurements and Disclosures Topic*, ASC 820-10.

Fair Value Disclosures

The following section applies the ASC 820-10 fair value hierarchy and disclosure requirements to our financial instruments that we carry at fair value. ASC 820-10 establishes a fair value hierarchy that prioritizes the inputs in the valuation techniques used to measure fair value into three broad Levels, numbered 1, 2, and 3.

Level 1 observable inputs reflect quoted prices for identical assets or liabilities in active markets that we have the ability to access at the measurement date. We currently have no Level 1 securities.

Level 2 observable inputs, other than quoted prices included in Level 1, reflect the asset or liability or prices for similar assets and liabilities. Most debt securities are priced by vendors using observable inputs and we classify them within Level 2. Derivative instruments that are priced using models with observable market inputs, such as interest rate swap contracts, are also reflected as Level 2.

Level 3 valuations are derived from techniques in which one or more of the significant inputs, such as assumptions about risk, are unobservable. Generally, Level 3 securities are less liquid securities such as highly structured or lower quality asset-backed securities, known as ABS, and private placement securities. Because Level 3 fair values, by their nature, contain unobservable market inputs, as there is no observable market for these assets and liabilities, we must use considerable judgment to determine the Level 3 fair values. Level 3 fair values represent our best estimate of an amount that we could realize in a current market exchange absent actual market exchanges.

The following table presents our assets that we carry at fair value by ASC 820 hierarchy levels (in thousands):

	Total	Level 1	Level 2	Level 3(1)
December 31, 2016				
Assets:				
Fixed maturities, available for sale	$ 245,191	$ —	$ 245,158	$ 33
Equity securities	6,303	—	6,303	—
Total assets	$ 251,494	$ —	$ 251,461	$ 33
December 31, 2015				
Assets:				
Fixed maturities, available for sale	$ 281,776	$ —	$ 281,674	$ 102
Equity securities	6,352	—	6,352	—
Total assets	$ 288,128	$ —	$ 288,026	$ 102

(1) Level 3 securities are all mortgage-backed and asset-backed securities at December 31, 2016 and 2015 and represent private-placement securities that are thinly traded and priced using an internal model or modeled by independent brokers.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

6. FAIR VALUE MEASUREMENTS (Continued)

In many situations, inputs used to measure the fair value of an asset or liability position may fall into different levels of the fair value hierarchy. In these situations, we will determine the level in which the fair value falls based upon the lowest level input that is significant to the determination of the fair value.

Determination of fair values

The valuation methodologies used to determine the fair values of assets and liabilities under the "exit price" notion of ASC 820-10 reflect market participant objectives and are based on the application of the fair value hierarchy that prioritizes observable market inputs over unobservable inputs. We determine the fair value of our financial assets and liabilities based upon quoted market prices where available. The following is a discussion of the methodologies used to determine fair values for the financial instruments listed in the above table.

Valuation of Fixed Maturity Securities

We have engaged an investment advisor to manage a portion of our portfolio, perform investment accounting and provide valuation services. Securities prices are obtained by the advisor from independent pricing vendors, which are chosen based on their ability to support and price specified asset classes following the procedures outlined in the valuation policy reviewed and approved by us. The following are examples of typical inputs used by third party pricing vendors:

- reported trades;
- benchmark yields;
- issuer spreads;
- bids;
- offers; and
- estimated cash flows and prepayment speeds.

Based on the typical trading volumes and the lack of quoted market prices for fixed maturities, third party pricing services will normally derive the security prices through recent reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information as outlined above. If there are no recent reported trades, the third party pricing services may use matrix or model processes to develop a security price where the pricing services develop future cash flow expectations based upon collateral performance, discounted at an estimated market rate. The pricing for mortgage-backed and asset-backed securities reflects estimates of the rate of future prepayments of principal over the remaining life of the securities. The pricing services derive these estimates based on the characteristics of the underlying structure and prepayment speeds previously experienced at the interest rate levels projected for the underlying collateral.

The investment advisor uses their own rules-based pricing system to evaluate the prices it receives from various pricing vendors to ensure the data adheres to certain vendor-to-vendor and day-to-day variance tolerances. Exceptions to the rules are monitored, investigated and challenged, as needed. We review and test the security pricing procedures used to value our fixed maturity portfolio on an ongoing basis. Our procedures include review of the investment valuation policy and understanding of the

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

6. FAIR VALUE MEASUREMENTS (Continued)

procedures used to obtain investment valuations and review of pricing controls at our investment advisor. We also test the prices provided by the advisor monthly by comparing the data to another independent pricing source and monitoring the change in prices from month to month and upon sale of the security. Significant changes or variances are investigated and explained. During the year ended December 31, 2016, we did not modify any price provided by the advisor.

We have also reviewed the advisor's pricing services' valuation methodologies and related sources, and have evaluated the various types of securities in our investment portfolio to determine an appropriate fair value hierarchy level based upon trading activity and the observability of market inputs. Based on the results of this evaluation and investment class analysis, we classified each price into Level 1, 2, or 3. We classified most prices provided by third party pricing services into Level 2 because the inputs used in pricing the securities are market observable.

Due to a general lack of transparency in the process that brokers use to develop prices, we have classified most valuations that are based on broker's prices as Level 3. We may classify some valuations as Level 2 if we can corroborate the price. We have also classified internal model priced securities, primarily consisting of private placement asset-backed securities, as Level 3 because this model pricing includes significant non-observable inputs.

Changes in the fair value of our Level 3 financial assets were not material to our consolidated financial statements for the years ended December 31, 2016 and 2015.

Valuation of Equity Securities

We report equity securities at fair value in other assets in our consolidated balance sheets. Their fair value is based on quoted market prices, where available. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level 2.

Nonrecurring Fair Value Measurement—Traditional Insurance Business Held for Sale

On October 8, 2015, we entered into a definitive agreement to sell our Traditional Insurance business to Nassau. As of December 31, 2015, we determined that this business should be classified as held for sale and reported in discontinued operations. Consequently, the related assets and liabilities at December 31, 2015 were adjusted to fair value, resulting in an after tax loss of $133.8 million, including the write off of $60.4 million in intangible assets. Because of the nature of the valuation process, we have classified this nonrecurring fair value measurement as Level 3. This transaction closed on August 3, 2016. For further details, see Note 21—Discontinued Operations.

7. GOODWILL AND INTANGIBLE ASSETS

Our consolidated balance sheets include goodwill held in connection with our Medicare Advantage reporting unit of $68.4 million at December 31, 2016 and 2015. There were no changes in carrying amounts during the years then ended.

We test goodwill for impairment annually based on information as of October 1 of the current year or more frequently if circumstances suggest that impairment may exist. During the quarter ended December 31, 2016, we performed our annual assessment of goodwill based on information as of

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

7. GOODWILL AND INTANGIBLE ASSETS (Continued)

October 1, 2016. We determined based on our "Step 1" impairment test that our estimated fair value of our Medicare Advantage reporting unit was in excess of its carrying value by more than 100%. We do not have goodwill assigned to any other reporting units.

The following table shows the Company's acquired intangible assets that continue to be subject to amortization and the related accumulated amortization.

	Remaining Life (Years)	December 31, 2016		December 31, 2015	
		Value Assigned	Accumulated Amortization	Value Assigned	Accumulated Amortization
		(in thousands)			
Medicare Advantage:					
Membership base	6	$ 17,917	$ 16,284	$ 17,917	$ 15,674
Provider contracts	<1	1,954	1,892	1,954	1,742
Non-compete	4	1,000	248	650	75
Total		$ 20,871	$ 18,424	$ 20,521	$ 17,491

The following table shows the changes in the amortizing intangible assets:

	2016	2015
	(in thousands)	
Balance, beginning of year	$ 3,030	$ 4,490
Additions and adjustments	350	650
Amortization	(933)	(2,110)
Balance, end of year	$ 2,447	$ 3,030

Estimated future net amortization expense (in thousands) is as follows:

2017	$ 805
2018	442
2019	402
2020	368
2021	152
Thereafter	278
Total	$ 2,447

See Note 3—Summary of Significant Accounting Policies, for additional information regarding our calculation of goodwill and other intangible assets.

8. REINSURANCE

Reinsurance—Continuing Operations

In the normal course of business, we reinsure certain Medicare Advantage policies, typically through excess of loss reinsurance agreements with unaffiliated companies whereby we limit our loss in excess of specified thresholds.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

8. REINSURANCE (Continued)

We evaluate the financial condition of our reinsurers and monitor concentrations of credit risk to minimize our exposure to significant losses from reinsurer insolvencies. We are obligated to pay claims in the event that a reinsurer to whom we have ceded an insured claim fails to meet its obligations under the reinsurance agreement. We are not aware of any instances where any of our reinsurers have been unable to pay any policy claims on any reinsured business.

Premium ceded on our Medicare Advantage business was $1.1 million and $1.9 million for the years ended December 31, 2016 and 2015, respectively, less than 0.2% of direct premiums in both periods.

Reinsurance recoverable on our Medicare Advantage business totaled $1.1 million and $0.4 million at December 31, 2016 and 2015, respectively, related to amounts due from reinsurers on paid claims, commissions and expense allowances net of premiums reinsured.

Reinsurance—Traditional Insurance—Discontinued Operations

On August 3, 2016, as discussed in Note 21—Discontinued Operations, we completed the sale of our Traditional Insurance business. This was accomplished by selling two of our life insurance subsidiaries, however we retained ownership of a third life insurance subsidiary, Progressive, in which we also write our New York and Maine Medicare Advantage business. The sale of the Traditional Insurance business underwritten by Progressive was accomplished through a 100% quota-share reinsurance treaty with Constitution Life that, when considered in combination with other reinsurance transactions previously entered into, results in the reinsurance of all of the Traditional Insurance policies that were underwritten on Progressive.

Progressive's traditional accident and health insurance products are generally reinsured under quota share coinsurance treaties with unaffiliated insurers, while the life insurance risks are reinsured under either quota share coinsurance or yearly-renewable term treaties with unaffiliated insurers. Under quota share coinsurance treaties, we pay the reinsurer an agreed upon percentage of all premiums and the reinsurer reimburses us that same percentage of any losses. In addition, the reinsurer pays us certain allowances to cover commissions, the cost of administering the policies and premium taxes. Under yearly-renewable term treaties, the reinsurer receives premiums at an agreed upon rate for its share of the risk on a yearly-renewable term basis. We also use excess of loss reinsurance agreements for certain policies whereby we limit our loss in excess of specified thresholds.

We evaluate the financial condition of our Traditional Insurance reinsurers and monitor concentrations of credit risk to minimize our exposure to significant losses from reinsurer insolvencies. We are obligated to pay claims in the event that a reinsurer to whom we have ceded an insured claim fails to meet its obligations under the reinsurance agreement. We are not aware of any instances where any of our reinsurers have been unable to pay any policy claims on any reinsured business.

As of December 31, 2016, all of our primary reinsurers, were rated "A–" (Excellent) or better by A.M. Best. For one reinsurer, a trust containing assets at 106% of reserves was established at the inception of the reinsurance agreement. The trust agreement requires that on an ongoing basis the trust assets be maintained at a minimum level of 100% of reserves. The reserves amounted to approximately $46.9 million as of December 31, 2016.

In accordance with ASC 944, *Financial Services—Insurance Topic*, reinsurance recoverables are to be reported as separate assets rather than as reductions of the related liabilities.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

8. REINSURANCE (Continued)

Reinsurance Recoverables: Amounts recoverable from our Traditional Insurance reinsurers, which are reported in assets of discontinued operations, are as follows:

	2016	2015
	(in thousands)	
Reinsurer		
Commonwealth and affiliates	$ 46,047	$ 198,180
Pennsylvania Life	—	135,546
Athene Life Re	46,850	77,900
Constitution Life	10,686	—
Hannover	65	17,750
Swiss Re	2,481	19,862
Other life	8,803	27,625
Total life	114,932	476,863
Constitution Life	23,125	—
Gen Re	22,948	78,112
Hannover	7,390	17,919
Pennsylvania Life	—	17,849
Other health	4,204	14,027
Total health	57,667	127,907
Total	$ 172,599	$ 604,770

At December 31, 2016, the total amount recoverable from Traditional Insurance reinsurers was $172.6 million including $172.6 million recoverable on future policy benefits and unpaid claims and less than $0.1 million for amounts due from reinsurers on paid claims, commissions and expense allowances net of premiums reinsured. At December 31, 2015, the total amount recoverable from Traditional Insurance reinsurers was $604.8 million including $596.2 million recoverable on future policy benefits and unpaid claims, $6.6 million in funds held and $2.0 million for amounts due from reinsurers on paid claims, commissions and expense allowances net of premiums reinsured.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

9. POLICY AND CONTRACT CLAIMS

Liabilities for Policy and Contract Claims: Activity in the liability for policy and contract claims is as follows:

	For the years ended December 31,	
	2016	2015
	(in thousands)	
Balance at beginning of year	$ 86,976	$ 94,836
Less reinsurance recoverable	—	(394)
Net balance at beginning of period	86,976	94,442
Balances sold	—	(66)
Incurred related to:		
Current year	1,154,487	1,079,803
Prior year development	(660)	(5,329)
Total incurred	1,153,827	1,074,474
Paid related to:		
Current year	1,097,327	999,225
Prior year	60,578	82,649
Total paid	1,157,905	1,081,874
Balance at end of year	$ 82,898	$ 86,976

The liability for policy and contract claims decreased from $87.0 million to $82.9 million during the year ended December 31, 2016. The decrease in the liability was primarily attributable to the decrease in IBNR for our Medicare Advantage business due to lower inventory levels.

The prior year development incurred in the table above represents (favorable) or unfavorable adjustments as a result of prior year claim estimates being settled or currently expected to be settled, for amounts that are different than originally anticipated. This prior year development occurs due to differences between the actual medical utilization and other components of medical cost trends, and actual claim processing and payment patterns compared to the assumptions for claims trend and completion factors used to estimate our claim liabilities.

The claim reserve balances at December 31, 2015 settled during 2016 for $0.7 million less than originally estimated. This prior year development represents less than 0.1% of the incurred claims recorded in 2015.

The claim reserve balances at December 31, 2014 settled during 2015 for $5.3 million less than originally estimated. This prior year development represents less than 0.5% of the incurred claims recorded in 2014.

Incurred and paid claims development: The following tables provide information about incurred and paid claims development as of December 31, 2016, net of reinsurance, as well as cumulative claim frequency and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. The information about incurred and paid claims development for the year ended December 31, 2015 is presented as supplementary information and is unaudited where

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

9. POLICY AND CONTRACT CLAIMS (Continued)

indicated. The cumulative number of reported claims indicated below are occurrence-based, where multiple claims submitted for the same medical event are counted as one claim. (Amounts are in thousands).

Medicare Advantage:

Cumulative Incurred Claims and Claims Adjustment Expenses, Net of Reinsurance			As of December 31, 2016	
	For the period through December 31,			
Incurred Year	2015	2016	Total IBNR Liability Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
2015	$ 1,079,803	$ 1,079,057	$ 18,479	2,401
2016		1,154,487	57,160	2,373
	Total	$ 2,233,544	$ 75,639	4,774

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
	For the period through December 31,	
Incurred Year	2015	2016
2015	$ 999,225	$ 1,060,578
2016		1,097,327
	Total	$ 2,157,905

Following is a reconciliation of incurred and paid claims to our policy and contract claims liability at December 31, 2016:

Incurred Claims and Claims Adjustment Expenses, Net of Reinsurance	$ 2,233,544
Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	(2,157,905)
All outstanding liabilities before 2015	7,259
Total liability for policy and contract claims, net of reinsurance at December 31, 2016	$ 82,898

The following table provides supplementary information about average historical claims duration as of December 31, 2016:

Average Annual Percentage Payout of Incurred Claims by Age, Net of Reinsurance		
Year	1	2
Medicare Advantage	93.8%	5.7%

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

10. INCOME TAXES

Our federal and state income tax expense (benefit) is as follows:

	2016	2015	2014
		(in thousands)	
Current—Federal	$ (15,005)	$ 7,567	$ 2,896
Current—States	642	(544)	(383)
Deferred—Federal	23,593	(3,128)	(8,712)
Deferred—States	114	(110)	92
Provision for (benefit from) income taxes	$ 9,344	$ 3,785	$ (6,107)

For the year ended December 31, 2016, we will file a consolidated federal income tax return that includes most corporate subsidiaries but excludes any subsidiary that qualifies as a life insurance company or is taxed as a partnership under the Internal Revenue Code. Subsidiaries that qualify as life insurance companies and partnerships will file separate federal income tax returns. We will include the taxable income or loss from a subsidiary taxed as a partnership in the tax return of its corporate owner.

A reconciliation of "expected" tax at 35% with our actual tax applicable to income (loss) from continuing operations before income taxes reported in the consolidated statements of operations is as follows:

	2016	2015	2014
		(in thousands)	
Expected tax expense (benefit)	$ 1,069	$ 31	$ (11,450)
State taxes, net of valuation allowances	250	(18)	379
Change in valuation allowance	—	124	(126)
Examination and related adjustments	—	2	(1,740)
Stock-based compensation (IRC 162 (m) & (m)(6))	34	20	(3,192)
ACA Fee	7,606	8,921	7,995
Preferred dividend	1,254	1,254	1,254
Sale of subidiaries	—	(4,436)	1,412
Fair Value Adjustment—Traditional Insurance	(608)	(2,400)	—
Change in unrecognized tax benefits	(323)	314	(107)
Other, net	62	(27)	(532)
Actual tax expense (benefit)	$ 9,344	$ 3,785	$ (6,107)

Our effective tax rate from continuing operations was a provision in excess of 100% for 2016 and 2015, compared with a benefit of 19% for 2014. The effective rate in 2016, 2015 and 2014 differs from the expected benefit of the 35% federal rate due to permanent items, primarily the ACA fee and preferred dividends, as well as state income taxes, net of non-recurring tax benefits.

Non-recurring tax benefits (expenses) included in income taxes amounted to $0.6 million, $6.5 million and $5.8 million for the years ended December 31, 2016, 2015 and 2014, respectively. The 2016 benefit relates primarily to release of a reserve on foreign tax credits. The 2015 benefit primarily relates to $4.3 million in foreign tax credit carryforwards created in connection with the February 2015 sale of APS Puerto Rico, net of valuation allowance and a $2.4 million net capital loss created in connection with the Traditional Insurance business fair value adjustment, net of valuation allowance.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

10. INCOME TAXES (Continued)

Any utilization of these tax benefits in the future will require sufficient taxable income, of the appropriate character, from continuing sources; consequently, they are included in continuing operations. The 2014 benefit primarily relates to the reversal of executive compensation previously considered non-deductible under Code section 162(m)(6) that resulted in the recording of a $3.2 million benefit for amounts considered non-deductible in our prior year tax return, recording of $1.3 million of foreign tax credits and a $0.7 million reserve release related to items on which the statute of limitations has expired.

In addition to federal and state income tax, our insurance company subsidiary is subject to state premium taxes, which are included in other operating costs and expenses in the consolidated statements of operations.

Deferred income taxes reflect the net tax effects of temporary differences between the carrying value of assets and liabilities for financial reporting purposes and the amount used for income tax purposes. The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and deferred tax liabilities are as follows:

	2016	2015
	(in thousands)	
Deferred tax assets:		
Net operating loss carryforwards	$ 5,833	$ 8,655
Stock-based compensation	4,942	7,548
Investments	—	783
Unrealized loss on investments	208	—
Deferred policy acquisition costs	2,446	2,165
Capital loss carryforwards	11,946	—
Credit carryforwards	21,723	19,350
Reserves and other policy liabilities	5,876	3,097
Accrued expenses and other liabilities	4,469	4,528
Fair Value Adjustment—Traditional Insurance	99	41,182
Net Amount Payable to Discontinued Operations	—	490
Other assets	333	20
Total gross deferred tax assets	57,875	87,818
Less valuation allowance	(20,345)	(36,898)
Net deferred tax assets	37,530	50,920
Deferred tax liabilities:		
Convertible Debt	(7,004)	—
Present value of future profits and other intangible assets	(789)	(902)
Investments	(601)	—
Unrealized gains on investments	—	(994)
Other Liabilities	(540)	(320)
Total gross deferred tax liabilities	(8,934)	(2,216)
Net deferred tax asset	$ 28,596	$ 48,704

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

10. INCOME TAXES (Continued)

We establish valuation allowances based on the consideration of both positive and negative evidence. We weigh such evidence through an analysis of future reversals of existing taxable temporary differences, future taxable income exclusive of reversing temporary differences and carryforwards, taxable income in prior carryback years, and our ability to implement prudent and feasible tax planning strategies.

In accordance with ASC Topic 740-10, *Income Taxes* (ASC 740), a valuation allowance is deemed necessary when, based on the weight of the available evidence, it is more likely than not (a likelihood of more than 50%) that some portion or all of a deferred tax asset will not be realized. The future realization of the tax benefit depends on the existence of sufficient taxable income within the carryback and carryforward periods.

In our consideration of the available evidence, we provided more weight to evidence that was more objectively verifiable. In 2016, significant weight was given to our cumulative income/loss position. Our cumulative loss position at December 31, 2016 was due in large part to losses in our APS Healthcare businesses that were sold during 2015 and are reported in discontinued operations, the fair value adjustment and ultimate sale of our Traditional Insurance business that is held for sale and reported in discontinued operations, the cumulative losses on our ACO business which include startup costs and a time lag in the recognition of revenue, the recognition of significant legal/settlement costs related to our non-core businesses and significant non-deductible expenses, particularly the ACA fee. While the Company is in a cumulative net loss position over the last three years from a financial reporting perspective, the Company has cumulative pre-tax income over the same period, after these adjustments are made.

We believe that the negative evidence of our cumulative loss is not indicative of future projected income or our ability to realize the deferred tax assets existing as of December 31, 2016. The remaining deferred tax assets, for which a valuation allowance was not established, relate to amounts that can be realized through future reversals of existing taxable temporary differences, prudent and feasible tax planning strategies and the Company's estimates of future taxable income. Any 2016 U.S. tax losses in our consolidated income tax return can be carried back to 2014 for ordinary losses and 2013 for capital losses, subject to certain limitations.

The significant tax attributes that create deferred tax assets include foreign tax credit and capital loss carryforwards. To use the foreign tax credit carryforwards, two conditions must be met. There must be foreign source income and there must be taxable income after application of any loss carryforwards. Based upon reversing timing items and projected income we expect taxable income and foreign source income to be sufficient to utilize almost all the foreign tax credit carryforward. However, we do not expect to have sufficient future capital gains income to fully utilize the capital loss carryforward. As a result, at December 31, 2016, we carried valuation allowances on our foreign tax credits and capital loss carryforwards of $0.9 million and $13.4 million, respectively.

For state deferred tax assets we performed an analysis that considered taxable unit (consolidated or separate filing) and taxing jurisdiction (federal or state). We established valuation allowances for several subsidiaries' state net operating losses and state deferred tax assets for which we do not believe there is sufficient positive evidence to conclude that it is more likely than not that the Company will realize these deferred tax assets. As a result, at December 31, 2016, we carried valuation allowances on our state deferred tax assets of $6.0 million.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

10. INCOME TAXES (Continued)

We carried valuation allowances for our continuing and discontinued operations on our deferred tax assets of $20.3 million at December 31, 2016 and $36.9 million at December 31, 2015, primarily related to foreign tax credit carryforwards that were created from the sale of our Puerto Rico subsidiaries, and those we acquired in connection with our purchase of APS Healthcare in 2012, state net operating loss carryforwards, deferred income tax assets for various states and the deferred tax asset generated by the capital loss on the sale of our Traditional Insurance business.

At December 31, 2016, we have $34.1 million of capital loss carryforwards that expire in 2021, $21.3 million of foreign tax credit carryforwards that expire in 2025 and $0.4 million of domestic alternative minimum tax credits that do not expire.

A federal tax return, generally, is open for examination for three years from the date on which it is filed, or, if applicable, from the extended due date unless the statute is extended by mutual consent. We have not entered into any agreement to extend the statute of limitations of any state tax return for any jurisdiction. During 2014, the IRS finished its examination of the Company's federal consolidated return for the period ending April 30, 2011 and associated net operating loss carryback claims resulting in a refund of $0.3 million. During 2016, we agreed to extend the federal statute for 2012 because of an existing outstanding refund claim that is subject to Joint Committee on Taxation approval. We participate in the Compliance Assurance Process under which the IRS performs a near-contemporaneous examination. Certain earlier returns remain open to the extent that net operating loss carry forwards were used or generated in those years. Also, various state tax returns remain open for examination under specific state statutes of limitation for an additional period of time.

Our unrecognized tax benefits at December 31, 2016 primarily relate to refund claims filed in various state jurisdictions during 2010 and the additional expected benefit from the April 30, 2011 federal return. We expect that a significant portion of the unrecognized state tax benefits will be resolved within the next twelve months based on the time frame in which we expect to actively pursue the collection of the refund claims filed in various state jurisdictions during 2010. Currently an estimate of the range of the possible collections cannot be made due to the uncertainty of the success of the collection efforts. A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

	2016	2015
	(in thousands)	
Balance as of January 1	$ 1,453	$ 1,130
Additions based on tax positions related to prior years	—	323
Subtractions based upon tax positions related to prior years	(1,453)	—
Balance as of December 31	—	1,453
Federal income tax effect	—	(290)
Balance, net of tax as of December 31	$ —	$ 1,163

Unrecognized tax benefits, if recognized, will impact the effective tax rate. The unrecognized tax benefits noted above relate to various state refund claims and various federal and state statute of limitation expirations. We recognize interest and penalties related to unrecognized tax benefits in federal and state tax expense. During the years ended December 31, 2016, 2015 and 2014, we

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

10. INCOME TAXES (Continued)

recognized no such interest expense and penalties. At December 31, 2016 and 2015, the Company had no accrued interest and penalties.

11. CONVERTIBLE SENIOR NOTES DUE 2021; STOCK REPURCHASE

On June 27, 2016, we completed an offering of $115.0 million of our 4.00% Convertible Senior Notes due 2021 (the "Convertible Notes"). The Convertible Notes are senior unsecured obligations of the Company. Interest on the Convertible Notes is payable on June 15 and December 15 of each year, commencing on December 15, 2016 until their maturity date of June 15, 2021. We may not redeem the Convertible Notes prior to the maturity date.

Prior to the close of the business day immediately preceding December 15, 2020, the Convertible Notes will be convertible only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on September 30, 2016 (and only during such calendar quarter), if the daily volume-weighted average price, or VWAP, of the common stock for at least 20 trading days (whether or not consecutive) during a period of thirty consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period after any five consecutive trading day period (the "measurement period") in which the trading price per $1,000 principal amount of notes for each trading day of the measurement period was less than 98% of the product of the daily VWAP of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events.

On or after December 15, 2020 until the close of business on the business day immediately preceding the maturity date, holders may convert their notes at any time, regardless of the foregoing circumstances. Upon conversion, we may satisfy our conversion obligation by paying or delivering, as applicable, cash, shares of our voting common stock or a combination of cash and shares of voting common stock, at our election.

The Convertible Notes will be convertible at an initial conversion rate of 105.8890 shares of our voting common stock per $1,000 principal amount of the Convertible Notes, which is equivalent to an initial conversion price of approximately $9.44. The conversion rate will be subject to adjustment in certain events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will increase the conversion rate for a holder who elects to convert its notes in connection with such a corporate event in certain circumstances, including customary conversion rate adjustments in connection with a "make-whole fundamental change."

We allocated the principal amount of the Convertible Notes between its liability and equity components (see table below). The carrying amount of the liability component was determined by measuring the fair value of a similar debt instrument of similar credit quality and maturity that did not have the conversion feature. The carrying amount of the equity component, representing the embedded conversion option, was determined by deducting the fair value of the liability component from the principal amount of the Convertible Notes as a whole. The equity component was recorded to additional paid-in capital and is not remeasured as long as it continues to meet the conditions for equity classification. The excess of the principal amount of the Convertible Notes over the carrying amount of the liability component was recorded as a debt discount, and is being amortized to interest expense using an effective interest rate of 8.5% over the term of the Convertible Notes. We allocated

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

11. CONVERTIBLE SENIOR NOTES DUE 2021; STOCK REPURCHASE (Continued)

the total amount of transaction costs incurred to the liability and equity components using the same proportions as the proceeds from the Convertible Notes. Transaction costs attributable to the liability component were recorded as a direct deduction from the liability component of the Convertible Notes, and are being amortized and recorded in other operating expenses using the effective interest method through the maturity date. Transaction costs attributable to the equity component were netted with the equity component of the Convertible Notes in additional paid-in capital.

The Convertible Notes consist of the following components (in thousands):

	December 31, 2016
Liability component:	
Principal	$ 115,000
Conversion feature	(20,637)
Amortization	2,127
Principal balance in liabilities	96,490
Liability portion of debt issuance costs	(3,593)
Net carrying amount	$ 92,897
Equity component:	
Conversion feature	$ 20,637
Equity portion of debt issuance costs	(875)
Deferred taxes	(6,917)
Net carrying amount	$ 12,845

We used the net proceeds from the Convertible Notes, together with cash on hand, to (i) repurchase all (a) 11,011,515 shares of our common stock held by certain affiliates of Perry Capital ("Perry") and (b) 7,098,775 shares of our common stock held by certain affiliates of Welsh, Carson, Anderson & Stowe ("WCAS"), at a purchase price of $6.80 per share, for an aggregate purchase price of approximately $123.0 million, and (ii) repurchase 2,082,800 shares of our common stock for an aggregate purchase price of approximately $15.1 million from purchasers of the convertible notes in privately negotiated transactions.

We recognized interest expense on the Convertible Notes of $4.5 million for the year ended December 31, 2016, which included $2.1 million of non-cash interest expense, representing amortization of the discount on the carrying amount of the Convertible Notes.

Following the consummation of the WellCare Transaction, each holder of the Company's Convertible Notes that remain outstanding at such time will have the right to (i) convert its notes into the right to receive the merger consideration under the WellCare Transaction, which amount will be calculated using an increased conversion rate because the transaction will constitute a "Make-Whole Fundamental Change" under the terms of the notes, or (ii) require that the Company repurchase its notes, which repurchase shall be for the principal amount plus accrued interest and settled in cash. These conversion and repurchase rights will be exercisable during an approximately 30 day period specified by the Company following consummation of the WellCare Transaction.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

12. MANDATORILY REDEEMABLE PREFERRED SHARES

On April 29, 2011, in conjunction with the sale of our Medicare Part D business, Universal American issued an aggregate of $40 million of Series A Mandatorily Redeemable Preferred Shares (the "Series A Preferred Shares"), representing 1,600,000 shares with a par value of $0.01 per share and a liquidation preference of $25.00 per share. The Series A Preferred Shares pay cash dividends at the rate of 8.5% per annum and are mandatorily redeemable on the six year anniversary of the issue date. There is no ability to call these securities before maturity except in the event of a change in control. The proceeds from the sale of the Series A Preferred Shares were used to pay a portion of the existing indebtedness of the Company prior to the sale and transaction expenses. We did not retain any proceeds from the sale of the Series A Preferred Shares. At the closing of the sale of our Medicare Part D business, certain officers and directors of the Company collectively purchased an aggregate of $10 million of the Series A Preferred Shares and we capitalized issue costs of approximately $1.1 million.

In accordance with ASC 480, *Distinguishing Liabilities from Equity*, because the issuance of the Series A Preferred Shares imposes an obligation on us requiring the transfer of assets, specifically, cash, at the redemption date, the Series A Preferred Shares are reported as a liability on the consolidated balance sheets, net of unamortized issue costs, with the related dividends reported as interest expense on the consolidated statements of operations. At December 31, 2016 and 2015 we had accrued $0.7 million of such dividends, recorded in other liabilities in the consolidated balance sheets.

Closing of the pending WellCare transaction would constitute a change in control with respect to the Series A Preferred Shares and would accelerate their settlement should the transaction close before the scheduled April 29, 2017 maturity of the Series A Preferred Shares.

13. DISCLOSURES ABOUT FAIR VALUES OF FINANCIAL INSTRUMENTS

We used the following methods and assumptions estimate the fair value of each class of financial instruments for which it is practicable to estimate that value:

Fixed maturity investments available for sale: See Note 6—Fair Value Measurements above.

Short-term investments and Cash and cash equivalents: For short-term investments and cash and cash equivalents, the carrying amount is a reasonable estimate of fair value.

Other invested assets: Other invested assets consists of cost-basis equity investments which are carried at the lower of cost or fair value, equity securities which are carried at their current fair value of $6.3 million and collateral loans. Other than the equity securities, the determination of fair value for these invested assets is not practical because there is no active trading market for such invested assets and therefore, the carrying value is a reasonable estimate of fair value.

Convertible Senior Notes due 2021, net of fees: For the Convertible Senior Notes due 2021, fair value represents the present value of contractual cash flows discounted at current market rates for securities of equivalent credit quality.

Series A mandatorily redeemable preferred shares: For the Series A mandatorily redeemable preferred shares fair value represents the present value of contractual cash flows discounted at current market rates for securities of equivalent credit quality.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

13. DISCLOSURES ABOUT FAIR VALUES OF FINANCIAL INSTRUMENTS (Continued)

The estimated fair values of the Company's financial instruments are as follows:

	2016		2015	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	(in thousands)			
Financial assets:				
Fixed maturities available for sale	$ 245,191	$ 245,191	$ 281,776	$ 281,776
Other invested assets	6,303	6,303	9,734	9,734
Cash and cash equivalents	104,462	104,462	70,546	70,546
Financial liabilities:				
Convertible Senior Notes due 2021, net of fees	92,897	144,955	—	—
Series A mandatorily redeemable preferred shares	39,939	41,231	39,755	41,150

For ASC 820-10 hierarchy levels for our fixed maturities and other invested assets see Note 6—Fair Value Measurements. Cash and cash equivalents are designated Level 1. For our Convertible Senior Notes due 2021, the fair value is based on quoted market prices. This security is designated Level 2. For our Series A mandatorily redeemable preferred shares, quoted market prices are not available and the fair value is estimated by the present value of contractual cash flows discounted at current market rates for securities of equivalent credit quality. These securities are designated Level 3.

14. STOCKHOLDERS' EQUITY

Preferred Stock: We currently have 40 million shares of preferred stock authorized for issuance, of which 1.6 million shares of Series A Mandatorily Redeemable Preferred Shares are issued and outstanding at December 31, 2016 and 2015. These amounts are recorded as a liability on the consolidated balance sheets (see Note 12—Mandatorily Redeemable Preferred Shares).

Common Stock—Voting: We currently have 400 million shares of voting common stock, par value $0.01 per share authorized for issuance. Changes in the number of shares of common stock issued were as follows (in thousands):

	2016	2015
Common stock issued, beginning of year	81,312	80,436
Issuance of common stock	502	618
Exercise of stock options	259	258
Share buyback/cancellation	(23,165)	—
Common stock issued, end of year	58,908	81,312

On June 27, 2016, in connection with the issuance of our convertible notes, we repurchased all 7,711,515 shares of our voting common stock held by Perry and 7,098,775 shares of our voting common stock held by WCAS. We also repurchased 2,082,800 shares of our voting common stock in privately negotiated transactions. See Note 11, *Convertible Senior Notes Due 2021; Stock Repurchase,* for additional information. On September 9, 2016, in connection with settlement of our litigation arising out of the APS Healthcare acquisition, we acquired all of the 6,272,104 shares of common stock held

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

14. STOCKHOLDERS' EQUITY (Continued)

by the defendants in such litigation. See Note 22, *Commitments and Contingencies*, for additional information.

Common Stock—Non-Voting: We have 60 million shares of non-voting common stock, par value $0.01 per share authorized for issuance, of which 3,300,000 shares were issued and outstanding at December 31, 2015. On June 27, 2016, we repurchased all 3,300,000 shares of our non-voting common stock held by Perry. See Note 11, *Convertible Senior Notes Due 2021; Stock Repurchase,* for additional information.

Accumulated Other Comprehensive (Loss) Income: The components of accumulated other comprehensive (loss) income, net of tax, are as follows (in thousands):

	Net Unrealized Gains on Investments Available for Sale	Gross Unrealized OTTI	Long-Term Claim Reserve Adjustment	Accumulated Other Comprehensive (Loss) Income
December 31, 2016				
Balance as of January 1, 2016	$ 6,090	$ —	$ (3,342)	$ 2,748
Other comprehensive loss before reclassifications	(4,311)	—	2,225	(2,086)
Less: Amounts reclassified from other comprehensive loss(1)	1,049	—	—	1,049
Net current-period other comprehensive loss	(5,360)	—	2,225	(3,135)
Balance as of December 31, 2016	$ 730	$ —	$ (1,117)	$ (387)
December 31, 2015				
Balance as of January 1, 2015	$ 19,088	$ —	$ (6,440)	$ 12,648
Other comprehensive loss before reclassifications	(10,582)	—	3,098	(7,484)
Less: Amounts reclassified from other comprehensive loss(1)	2,416	—	—	2,416
Net current-period other comprehensive loss	(12,998)	—	3,098	(9,900)

Balance as of December 31, 2015	$ 6,090	$ —	$ (3,342)	$ 2,748
December 31, 2014				
Balance as of January 1, 2014	$ 13,909	$ (1,107)	$ (5,473)	$ 7,329
Other comprehensive income before reclassifications	6,001	1,107	(967)	6,141
Less: Amounts reclassified from other comprehensive income(1)	822	—	—	822
Net current-period other comprehensive income	5,179	1,107	(967)	5,319
Balance as of December 31, 2014	$ 19,088	$ —	$ (6,440)	$ 12,648

Table amounts are presented net of tax at a rate of 35%.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

14. STOCKHOLDERS' EQUITY (Continued)

(1) Reclassed from net realized gains (losses) in the Consolidated Statements of Operations.

Special Cash Dividend: On October 26, 2015, we paid a special cash dividend of $0.75 per share, to shareholders of record on October 19, 2015. The total dividend was $63.0 million. This dividend is a liquidating dividend and was recorded as a reduction of additional paid-in capital.

A portion of each special cash dividend is recorded as a dividend payable liability expected to be paid in the future to holders of our restricted stock as such shares vest. This liability was $0.8 million and $1.6 million at December 31, 2016 and 2015, respectively, and is included in other liabilities in the consolidated balance sheets. In addition, pursuant to the terms of our 2011 Equity Award Plan, each dividend reduces the exercise price on outstanding stock options as of the ex-dividend date by the amount of the dividend.

Earnings per Common Share: Under ASC 260, *Earnings Per Share*, income (loss) from continuing operations is the trigger for determining whether potential common stock equivalents are dilutive or anti-dilutive when calculating diluted earnings per share. Diluted EPS includes the dilutive effect of the unvested restricted stock and stock options outstanding during the year.

For the years ended December 31, 2016, 2015 and 2014, Universal American had losses from continuing operations and accordingly, excluded common stock equivalents of 0.8 million, 1.3 million and 0.6 million, respectively, from the calculation of diluted earnings per share.

15. STOCK-BASED COMPENSATION

In 2011, we established the Universal American Corp. 2011 Omnibus Equity Award Plan (the "2011 Plan") to replace the 1998 Incentive Compensation Plan (the "1998 ICP"). The 2011 Plan is the sole active plan providing for the granting of various types of equity awards, including stock options, stock appreciation rights, restricted stock, restricted stock units, and other stock-based awards and/or performance compensation awards. The 2011 Plan is administered by the Compensation Committee of the Board of Directors. The aggregate number of shares of common stock available for awards under the 2011 Plan is 13,000,000. Universal American's stock-based compensation expense relates to the equity awards granted under the 2011 Plan as well as restricted stock and performance share awards that were granted under the 1998 ICP.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

15. STOCK-BASED COMPENSATION (Continued)

Compensation expense, included in other operating costs and expenses, and the related tax benefit were as follows:

	2016	2015	2014
		(in thousands)	
Stock options	$ 2,113	$ 4,124	$ 4,658
Restricted stock awards	4,784	6,513	5,389
Total stock-based compensation expense	6,897	10,637	10,047
Less: stock-based compensation expense—discontinued operations	109	1,337	834
Stock-based compensation expense—continuing operations	6,788	9,300	9,213
Tax benefit recognized	2,376	3,255	5,702
Stock-based compensation expense—continuing operations, net of tax	$ 4,412	$ 6,045	$ 3,511

(1) The tax benefit recognized in 2014 includes a benefit of $2.5 million from prior years that we previously estimated to be non-deductible. See Note 10—*Income Taxes*, for further discussion.

Stock Option Awards

We recognize compensation cost for share-based payments to employees, directors and other third parties based on the grant date fair value of the award, which we amortize over the grantees' service period in accordance with the provisions of *Compensation—Stock Compensation Topic*, ASC 718-10. We use the Black-Scholes valuation model to value stock options, except in the case of performance-based stock options, where we use a Monte Carlo valuation approach.

We estimated the fair value for options granted during the period at the date of grant with the following range of assumptions:

	For options granted		
	2016	2015	2014
Weighted-average grant date fair value	$1.54 - $2.04	$1.93 - $2.95	$2.11 - $2.59
Risk free interest rates	0.65% - 1.09%	1.14% - 1.32%	0.90% - 1.43%
Dividend yields	0.00%	0.00%	0.00%
Expected volatility	33.15% - 33.86%	32.44% - 34.60%	36.66% - 39.49%
Expected lives of options (in years)	3.75 - 4.00	3.75 - 5.00	3.75

We did not capitalize any cost of stock-based compensation. Future expense may vary based upon factors such as the number of awards granted by us and the then-current fair value of such awards.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

15. STOCK-BASED COMPENSATION (Continued)

A summary of option activity for the year ended December 31, 2016 is set forth below:

Options	Options (in thousands)	Weighted Average Exercise Price
Outstanding at January 1, 2016	4,871	$ 6.80
Granted	761	6.14
Exercised	(1,878)	6.31
Forfeited or expired	(220)	7.28
Outstanding at December 31, 2016	3,534	$ 6.89

	Shares Under Options (in thousands)	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value Per Share(1)	Aggregate Intrinsic Value (in thousands)
Options exercisable at December 31, 2016	1,755	$ 7.05	1.2	$ 2.91	$ 5,100
Options vested and expected to vest at December 31, 2016(2)	3,460	$ 6.89	2.1	$ 3.06	$ 10,592

(1) Computed based upon aggregate intrinsic value divided by shares under options.

(2) The Company estimates forfeitures in accordance with ASC 718 10, Compensation—Stock Compensation.

Options granted during 2016 and 2015 included 358,000 and 279,000 performance-based options, respectively, which vest ratably over a four-year period, but only if our stock price meets specified targets at the vesting dates. Vesting is cumulative, such that if a stock price target is missed on a vesting date, but a subsequent stock price target is met on a future vesting date, all previously unvested options would then vest. In addition, in the event of a Change in Control (as defined in the 2011 Equity Plan), all performance options will no longer vest in accordance with the performance-based criteria but instead shall vest as if such grants were originally granted as four-year time vested grants where 25% of such awards would vest on each of the first four anniversaries of the date of grant. These options were determined to contain a market condition for vesting under ASC 718—*Compensation—Stock Compensation*, and were valued using a Monte Carlo valuation approach.

The total intrinsic value of stock options (the amount by which the market price of the stock on the date of exercise exceeded the exercise price of the option) exercised during 2016, 2015 and 2014 were $3.3 million, $3.5 million and $0.3 million, respectively.

We received proceeds of $11.9 million, $9.5 million, and $1.9 million from the exercise of stock options during the years ended December 31, 2016, 2015, and 2014, respectively. Such proceeds were primarily non-cash, as substantially all

exercises were made on a net basis.

As of December 31, 2016, the total compensation cost related to non-vested awards not yet recognized was $2.0 million, which we expect to recognize over a weighted average period of 2.1 years.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

15. STOCK-BASED COMPENSATION (Continued)

Restricted Stock Awards

In accordance with our 2011 Equity Plan, we may grant restricted stock to employees, directors and other third parties. These awards generally vest ratably over a four-year period; however during the year ended December 31, 2014 we paid a portion of the annual bonuses in the form of restricted stock. The 2014 awards vest under certain circumstances on the one-year and two-year anniversary of the grant, respectively. We generally value restricted stock awards at an amount equal to the market price of our common stock on the date of grant, except in the case of performance-based awards, which we value using a Monte Carlo valuation approach. We recognize compensation expense for restricted stock awards on a straight line basis over the vesting period.

A summary of our non-vested restricted stock awards for the year ended December 31, 2016 is set forth below:

Non-Vested Restricted Stock	Shares (in thousands)	Weighted Average Grant-Date Fair Value
Non-vested at January 1, 2016	2,012	$ 5.66
Granted	858	5.16
Vested	(514)	8.26
Forfeited	(155)	6.36
Non-vested at December 31, 2016	2,201	$ 4.81

The total fair value of shares of restricted stock vested during the years ended December 31, 2016, 2015 and 2014 was $2.9 million, $8.4 million and $2.7 million, respectively.

Shares granted during 2016 and 2015 included 382,000 and 371,000 performance shares, respectively, which vest in the same manner as the performance options discussed above. These shares were determined to contain a market condition for vesting under ASC 718—*Compensation—Stock Compensation*, and were valued using a Monte Carlo valuation approach. In addition, 480,000 shares were granted during 2015 that only vest following a change-in-control transaction.

Tax Benefits of Stock-Based Compensation

ASC 718-10 requires us to report the benefit of tax deductions in excess of recognized compensation cost as a financing cash flow. We recognized $(2.2) million, $0.1 million and $(1.0) million of financing cash flows for these excess tax deductions for years ended December 31, 2016, 2015 and 2014, respectively.

16. UNIVERSAL AMERICAN CORP. 401(k) SAVINGS PLAN

Effective April 1, 1992, we adopted the Universal American Corp. 401(k) Savings Plan. The 401(k) plan is a voluntary contributory plan under which employees may elect to defer compensation for federal income tax purposes under Section 401 (k) of the Internal Revenue Code of 1986. The employee is entitled to participate in the 401(k) plan by contributing through payroll deductions up to 100% of the employee's compensation. The participating employee is not taxed on these contributions until they are distributed. Amounts credited to employee's accounts under the 401(k) plan are invested by the employer-appointed investment committee. Currently, we match employee contributions with our

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

16. UNIVERSAL AMERICAN CORP. 401(k) SAVINGS PLAN (Continued)

common stock in amounts equal to 100% of the employee's first 1% of contributions and 50% of the employee's next 4% of contributions to a maximum matching contribution of 3% of the employee's eligible compensation. Our matching contributions vest at the rate of 25% per plan year, starting at the end of the second year.

Participants have the option to transfer/reallocate at will, outside of blackout periods, both vested and unvested employer contributions invested in our common stock to any of the other investments available under the 401(k) plan. The 401(k) plan held 1.4 million shares of our common stock at December 31, 2016, which represented 17% of total plan assets and 1.4 million shares of our common stock at December 31, 2015, which represented 13% of total plan assets.

Generally, a participating employee is entitled to distributions from the 401(k) plan upon termination of employment, retirement, death or disability. 401(k) plan participants who qualify for distributions may receive a single lump sum, have the assets transferred to another qualified plan or individual retirement account, or receive a series of specified installment payments.

We made discretionary matching contributions under the 401(k) plan of $0.9 million in 2016, $1.7 million in 2015 and $1.8 million in 2014.

17. STATUTORY FINANCIAL DATA AND DIVIDEND RESTRICTIONS

Statutory Financial Data

Our regulated insurance and HMO subsidiaries are required to maintain minimum amounts of statutory capital and surplus as required by regulatory authorities. However, substantially more than such minimum amounts are needed to meet statutory and administrative requirements of adequate capital and surplus to support the current level of their operations. Each of our regulated subsidiaries' statutory capital and surplus are at levels we believe are sufficient to support their currently anticipated levels of operation. Additionally, the National Association of Insurance Commissioners, known as NAIC, imposes regulatory risk-based capital, known as RBC, requirements on these companies. At December 31, 2016, our regulated insurance and HMO subsidiaries maintained ratios of total adjusted capital to RBC in excess of the "authorized control level."

The combined statutory capital and surplus, including asset valuation reserve, of our regulated insurance and HMO subsidiaries, totaled $193.3 million and $286.1 million at December 31, 2016 and 2015, respectively. For the years ended December 31, 2016, 2015 and 2014, our insurance and HMO subsidiaries generated statutory net income of $21.6 million, $34.6 million and $7.3 million, respectively.

Based on current estimates, we expect the aggregate amount of dividends that may be paid by our insurance and HMO subsidiaries to our parent company in 2017 without prior approval by state regulatory authorities to be approximately $23 million.

Shareholder Dividend Restrictions

The payment of dividends to our shareholders is subject to the following restrictions:

- the ability of our operating subsidiaries to pay dividends to our parent holding company, which is governed by state law;
- Delaware law, governing the payment of dividends, which provides that dividends can only be paid out of surplus.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

18. RESTRUCTURING CHARGES

Over the last several years, we have initiated and executed various restructuring plans, as discussed below.

Workforce Reduction—In 2015, in connection with our continued efforts to reduce operating expenses, a workforce reduction plan was developed for implementation in late 2015 and 2016. As a result, in the fourth quarter of 2015, we committed to a plan to reduce our workforce in targeted areas, resulting in a charge of $1.1 million for severance and other benefits related to this plan.

In 2014, we made the decision to exit certain non-core markets in our Medicare Advantage business, stopped our participation in several underperforming ACOs, chose not to rebid on certain APS Healthcare contracts and exited the New York Health Benefits Exchange, known as the Exchange. During the fourth quarter of 2014 we committed to staff reductions across all segments continuing into 2015, resulting in a charge of $2.0 million. During 2015, additional staff reductions related to this plan resulted in additional charges of $0.7 million, which were also paid during 2015.

During 2015, we made payments of $3.8 million in connection with these workforce reduction programs, and have $1.2 million accrued at December 31, 2015, which we expect to pay in 2016.

New York Health Benefits Exchange Exit—Effective January 1, 2015, we discontinued our participation in the Exchange. We accrued $0.8 million at December 31, 2014 related to certain contractual charges and made payments of $0.7 million in connection with this plan.

Facility Consolidation—During 2015, we recorded a restructure charge of $5.6 million related to the sale of our APS Healthcare domestic business. In connection with the sale, we retained certain office space which we have exited and certain Managed Behavioral Health, known as MBH, contracts which we have terminated and are operating at a loss as the business runs off. Our restructure charge for facilities represents the estimated costs to close the facilities, including lease buyout costs and rent costs, net of estimated sublease revenue, on non-cancellable leases prior to termination. The related leases run through 2021. The charge related to the MBH contracts represents the estimated operating losses on the terminated contracts through the end of the contractual period, March 31, 2016. There were no additional charges under this APS Healthcare restructuring initiative.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

18. RESTRUCTURING CHARGES (Continued)

A summary of our restructuring liability balance as of December 31, 2016, 2015, and 2014 and restructuring activity for the years then ended is as follows:

	Segment	January 1 Balance	Charge to Earnings (1)	Cash Paid	Non-cash	December 31 Balance
				(in thousands)		
2016						
Continuing Operations:						
Workforce reduction	Corporate & Other	$ 1,150	$ (257)	$ (732)	$ —	$ 161
NY Exchange exit	Corporate & Other	28	—	—	(16)	12
Total Continuing Operations		1,178	(257)	(732)	(16)	173
Discontinued Operations:						
Workforce reduction		514	(4)	(34)	(476)	—
MBH runout		299	—	—	(299)	—
Facility consolidation		2,929	764	—	(1,080)	2,613
Total Discontinued Operations		3,742	760	(34)	(1,855)	2,613
Total		$ 4,920	$ 503	$ (766)	$ (1,871)	$ 2,786
2015						
Continuing Operations:						
Workforce reduction	Corporate & Other	$ 3,069	$ 1,897	$ (3,816)	$ —	$ 1,150
NY Exchange exit	Corporate & Other	804	(100)	(676)	—	28
Total Continuing Operations		3,873	1,797	(4,492)	—	1,178
Discontinued Operations:						
Facility consolidation		106	—	—	(106)	—
Workforce reduction		661	260	(407)	—	514
MBH runout		—	1,690	(1,391)	—	299
Facility consolidation		—	3,688	(254)	(505)	2,929
Total Discontinued Operations		767	5,638	(2,052)	(611)	3,742
Total		$ 4,640	$ 7,435	$ (6,544)	$ (611)	$ 4,920

2014						
Continuing Operations:						
Workforce reduction	Corporate & Other	$ 5,621	$ 1,969	$ (4,521)	$ —	$ 3,069
NY Exchange exit	Corporate & Other	—	804	—	—	804
Total Continuing Operations		5,621	2,773	(4,521)	—	3,873
Discontinued Operations:						
Facility consolidation		222	—	—	(116)	106
Workforce reduction		625	36	—	—	661
Total Discontinued Operations		847	36	—	(116)	767
Total		$ 6,468	$ 2,809	$ (4,521)	$ (116)	$ 4,640

(1) The charge to earnings for continuing operations is included in other operating costs and expenses in our consolidated statements of operations. The charge to earnings for discontinued operations is included in the loss from discontinued operations before income taxes in our consolidated statements of operations.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

19. UNCONSOLIDATED SUBSIDIARIES

We account for our participation in the ACOs using the equity method. Gains and losses are reported as equity in losses of unconsolidated subsidiaries in the consolidated statements of operations. Our net investment in the ACOs is reported in other assets in the consolidated balance sheets. We recognized equity in earnings (losses) of our unconsolidated ACOs of $5.0 million, $(9.6) million and $(17.8) million, for the years ended December 31, 2016, 2015 and 2014, respectively.

- On July 29, 2016, CMS informed us that our MSSP ACOs generated $97 million in gross savings for program year 2015. This compares to $80 million in gross savings for program year 2014, which we reported in the second quarter of 2015. 10 of our ACO's qualified for shared savings payments, compared to 9 in program year 2014, and received payments of $39.8 million, compared to $26.9 million in program year 2014. Our share of these payments for 2016, after payments to our physician partners of $11.3 million, is $28.5 million, compared to $20.9 million in 2015, and is reflected in equity in earnings (losses) of unconsolidated subsidiaries in our consolidated statements of operations. We received these payments during the third quarter of 2016.

On July 30, 2015, CMS informed us that our 23 Medicare Shared Savings Program, or MSSP, ACOs which were active in 2014, generated $80 million in gross savings for program year 2014. This compares to $66 million in gross savings for 2012/2013, the first program period of the MSSP, which comprised up to 21 months and which we reported in the third quarter of 2014. For these 23 ACOs, the program year 2014 results showed that:

- 9 ACOs, serving more than 105,000 Medicare beneficiaries, including our flagship ACO in Houston, qualified for shared savings totaling $26.9 million. This compares to $20.4 million in shared savings paid to ACOs for the first program year 2012/2013, which was longer. Our share of these payments, recorded in the second quarter of 2015, after payments to our physician partners of $6.0 million, increased to $20.9 million, which is reflected in equity in losses of unconsolidated subsidiaries in our consolidated statements of operations. We received these payments in October 2015;

- 8 additional ACOs achieved savings but did not exceed the Minimum Savings Rate, known as MSR. Of those eight, four missed the MSR by less than 1%; and

- Quality scores improved for all ACOs, which indicates improved healthcare management particularly for our chronically ill beneficiaries.

During September 2014, we received notice that the ACOs we formed in partnership with primary care physicians and other healthcare professionals generated $66 million in total program savings for CMS, as part of the Medicare Shared Savings Program for the first performance year of the MSSP (2012 and 2013). Of our 30 ACOs with start dates in 2012 and 2013, the results showed that:

- 3 ACOs, serving more than 56,000 Medicare beneficiaries and including our largest ACO in Houston, generated savings in excess of their Minimum Savings Rate and therefore, qualified to share those savings with CMS;

- 11 ACOs, serving more than 120,000 Medicare beneficiaries, generated savings but fell below their Minimum Savings Rate required to share savings with CMS;

- 8 ACOs were within 2 percent of their benchmark;

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

19. UNCONSOLIDATED SUBSIDIARIES (Continued)

- 8 ACOs were 2 percent or more above their benchmark; and
- All ACOs met CMS's quality reporting standards.

The three ACOs qualifying for savings received payments of $20.4 million, part to be shared between the physicians of those ACOs and us and part to be used by us to reimburse a portion of the costs that we had incurred. Our share of these savings, including expense recovery, amounted to $13.4 million, which is reflected in equity in losses of unconsolidated subsidiaries in our consolidated statements of operations. We received these payments in October 2014. We did not recognize any shared savings revenue in 2013.

During 2016, we operated one ACO under the new Next Generation ACO Model. This Next Generation ACO receives different beneficiary information from CMS during the year than the MSSP ACOs. During 2016, we were able to use this information to estimate Program Year 2016 revenue for this Next Generation ACO, but determined, based on the information available, that this ACO would not generate any shared savings. Based on our analysis, we accrued a $1.7 million estimated loss for 2016.

Following is a summary of shared savings revenue included in equity in earnings (losses) of our unconsolidated MSSP ACOs for the program years indicated:

	For the year ended		
	2016	2015	2014
	(in thousands)		
Program Year 2015	$ 29,232	$ —	$ —
Program Year 2014	—	20,884	—
Program Year 2013/2012	—	—	13,375
	$ 29,232	$ 20,884	$ 13,375

The condensed financial information for 100% of our unconsolidated ACOs is as follows:

	December 31,	
	2016	2015
	(in thousands)	
Total assets	$ 886	$ —
Total liabilities	$ 64,620	$ 66,741

	For the year ended December 31,		
	2016	2015	2014
	(in thousands)		
Total revenue	$ 38,138	$ 26,924	$ 20,357
Total expenses	23,695	31,700	31,168
Income (loss)	$ 14,443	$ (4,776)	$ (10,811)

For additional information on our ACOs, see Note 1—Organization and Company Background and Note 2—Basis of Presentation.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

20. SALES OF SUBSIDIARIES

The following transactions relate to subsidiaries of our Medicare Advantage segment:

Sale of SelectCare of Oklahoma: On December 31, 2014, we completed the sale of SCOK to Healthcare Investors, LLC. SCOK operated as a special needs HMO Medicare advantage plan in Oklahoma with approximately 120 members, representing approximately $3.2 million of annualized revenue. The purchase price at closing was $1.9 million and was settled in cash. At the date of sale, the carrying value of SCOK included $0.4 million of goodwill and indefinite-lived intangible assets that were disposed of in connection with the sale. The transaction resulted in a pre-tax realized loss of $0.6 million, or $0.5 million after taxes.

Sale of Today's Options of Oklahoma: On August 29, 2014, we completed the sale of TOOK to Momentum Health, LLC. TOOK operated an HMO Medicare Advantage plan in Oklahoma with approximately 5,800 members, representing approximately $63 million of annualized revenue. The purchase price was $15.5 million of which we received $15.2 million in cash at closing. The balance of $0.3 million is recorded as a receivable in other assets on the consolidated balance sheets and was settled in cash during the first quarter of 2015. At the date of sale, our carrying value of TOOK included $3.8 million of goodwill and $1.5 million of amortizing intangible assets that were disposed of in connection with the transaction. The transaction resulted in a pre-tax realized loss of $2.0 million, or $2.7 million after taxes.

21. DISCONTINUED OPERATIONS

The following transactions represent disposals or commitments to dispose of a reporting group and therefore they are reported as discontinued operations:

Sale of Traditional Insurance Business: On August 3, 2016 we completed the sale of our Traditional Insurance business to Nassau Re. Under the terms of the agreement, Nassau Re acquired all of the shares of Constitution Life and Pyramid, as well as the Traditional Insurance business written by Progressive on a 100% coinsurance basis. At closing, we received $30.5 million in cash, which, under the terms of the agreement, is subject to post-closing price adjustments based on actual capital and surplus of Constitution Life and Pyramid compared to the target statutory capital and surplus of $68.5 million In October 2016, we received $11.4 million representing final settlement of potential earn out payments from this sale and in January 2017 we received an additional $2.7 million in cash in final settlement of the post-closing balance sheet adjustments.

As of December 31, 2015, in accordance with ASC 360-10, *Property, Plant and Equipment* and ASC 205-20, *Presentation of Financial Statements—Discontinued Operations*, we determined that our Traditional Insurance business should be classified as held for sale and reported in discontinued operations. Under ASC 360-10-35, a long-lived asset classified as held for sale shall be measured at the lower of its carrying amount or fair value less cost to sell. We determined fair value at the balance sheet date, by calculating estimated net proceeds, using actual statutory surplus, estimating the likelihood of receiving any earn-out and estimating closing costs. Estimated net proceeds were compared to the GAAP book value of the entities being sold and the business being reinsured. At December 31, 2015, our analysis indicated a pre-tax loss of $149.2 million, generating a deferred tax benefit of $40.9 million, against which we recorded a $25.6 million valuation allowance, resulting in an after-tax loss of $133.8 million. Adjustments recorded in 2016 to true up the estimated fair value recorded at December 31, 2015, resulted in a $0.5 million gain. This included the reclassification of

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

21. DISCONTINUED OPERATIONS (Continued)

$4.8 million, after tax, of AOCI related to the sale of the Traditional Insurance business to the cumulative loss on the transaction. This was partially offset by a $1.0 million after-tax adjustment to reflect the early cash settlement of the earn-out and a contractual true up of the closing balance sheet of $2.3 million that was recorded in the fourth quarter. Additionally, discontinued operations treatment requires that the related assets and liabilities for the current period and all historical periods presented are reclassified as assets and liabilities held for sale in our consolidated balance sheets, and the related operating results and cash flows for the current period and all historical periods presented have been reclassified as discontinued operations in our consolidated financial statements.

In connection with the sale of our Traditional Insurance business, we agreed to provide certain support services to Nassau Re under a transition service agreement, or TSA. During the year ending December 31, 2016, we recognized fee income of $1.0 million.

Sale of Total Care Medicaid Plan: On August 1, 2016, we completed the sale of TONY, which operates the Total Care Medicaid Plan, to Molina for an adjusted purchase price of $38.0 million, subject to closing date balance sheet adjustments, resulting in a pre-tax gain of $20.4 million.

As of June 30, 2016, in accordance with ASC 360-10 and ASC 205-20, we determined that our Total Care business should be classified as held for sale and reported in discontinued operations. Additionally, discontinued operations treatment requires that the related assets and liabilities for all historical periods presented are reclassified as assets and liabilities held for sale in our consolidated balance sheets, and the related operating results and cash flows for the current period and all historical periods presented have been reclassified as discontinued operations in our consolidated financial statements.

In connection with the sale of the Total Care business, we agreed to provide certain support services to Molina under a TSA. During the year ending December 31, 2016, we recognized fee income of $0.4 million.

Sale of APS Healthcare: On February 4, 2015, we sold our APS Healthcare Puerto Rico subsidiaries to an affiliate of the Metro Pavia Health System. APS Puerto Rico provided managed behavioral health services under the Government Health Plan Medicaid program under a contract that terminated on March 31, 2015. The purchase price at closing was $26.5 million, which was settled in cash, subject to a balance sheet true-up. The transaction resulted in a pre-tax realized loss of approximately $0.4 million. The transaction also generated an additional foreign tax credit carryforward of $5.4 million that was recorded as a deferred tax asset.

On May 1, 2015, we sold our remaining APS Healthcare operating subsidiaries to KEPRO, Inc., a company that provides quality improvement and care management services to both government clients and the private sector. The purchase price was $5.0 million, which was settled in cash at closing, subject to a working capital true up, which was finalized during the quarter ended September 30, 2015. The transaction resulted in a pre-tax realized loss of $17.0 million in 2015, including the working capital true up.

In addition, the transaction included a potential earn-out based on certain contract renewals. Due to the variability in the length of time over which the contract renewals could occur and the difficulty of estimating the success of such renewals, we considered the potential earn-out to be a contingent gain which was recorded only if and when we determined it to be realizable. We recorded earn-out revenue of $12.1 million based on amounts received from the buyer through the third quarter of 2016 which represented the final settlement of earn-out revenue.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

21. DISCONTINUED OPERATIONS (Continued)

In connection with the sales of the APS businesses, we agreed to provide certain support services to the buyers under TSA's. During the year ended December 31, 2015, we recognized fee income of $2.9 million. All APS-related TSA services were completed as of December 31, 2015.

Effective with the sale of our APS Healthcare businesses, in accordance with ASC 205-20, the results of operations and cash flows related to APS Healthcare are reported as discontinued operations for all periods presented. In addition, the related assets and liabilities have been segregated from the assets and liabilities related to our continuing operations and are presented separately in our consolidated balance sheets as of December 31, 2016 and 2015, respectively.

Discontinued Operations Summary Financial Information: Summarized financial information for our discontinued operations is presented below:

	For the years ended December 31,		
	2016	2015	2014
		(in thousands)	
Revenues:			
Net premiums	$ 198,194	$ 372,523	$ 519,681
Net investment income	9,137	17,497	16,413
Fee and other income	916	32,484	89,642
Net realized gains (losses)	160	44	(733)
Total revenues	208,407	422,548	625,003
Benefits, claims and expenses:			
Claims and other benefits	172,427	328,948	441,013
Change in deferred policy acquisition costs	—	23,442	12,323
Amortization of intangible assets	470	1,449	2,269
Affordable Care Act fee	1,919	3,385	—
Other operating costs and expenses	28,567	87,124	170,608
Total benefits, claims and expenses	203,383	444,348	626,213
Operating income (loss)	5,024	(21,800)	(1,210)
Total Care—gain on sale	20,407	—	—
APS Healthcare (1)	41,746	(17,418)	—
Traditional Insurance—gain (loss) on sale	486	(149,153)	—
Income (loss) from discontinued operations before income taxes	67,663	(188,371)	(1,210)
Provision for (benefit from) income taxes	5,997	(28,098)	1,649
Income (loss) from discontinued operations	$ 61,666	$ (160,273)	$ (2,859)

(1) 2016 amounts include earn-out revenues and litigation settlement, while 2015 amounts represent initial loss on the sale of APS Healthcare. See Note 22—Commitments and Contingencies for additional information.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

21. DISCONTINUED OPERATIONS (Continued)

Total assets and liabilities of discontinued operations are as follows:

	December 31, 2016	December 31, 2015
	(in thousands)	
Assets		
Fixed maturities available for sale, at fair value	$ 51,997	$ 427,690
Other invested assets	—	12,800
Total investments	51,997	440,490
Cash and cash equivalents	1,967	6,628
Accrued investment income	591	3,196
Reinsurance recoverables—life	115,190	476,863
Reinsurance recoverables—health	57,409	130,501
Due and unpaid premiums	377	27,565
Goodwill and intangible assets	—	4,197
Deferred income tax asset	2,283	—
Income taxes receivable	—	10,194
Other healthcare receivables	—	2,045
Net amounts receivable from continuing operations	—	44,289
Other assets	—	4,602
Total assets	$ 229,814	$ 1,150,570
Liabilities		
Reserves and other policy liabilities—life	$ 115,374	$ 495,518
Reserves for future policy benefits—health	54,825	539,307
Policy and contract claims—health	2,694	38,482
Premiums received in advance	420	2,000
Amounts due to reinsurers	8,007	2,325
Deferred income tax liability	—	7,491
Other liabilities	56,442	30,916
Total liabilities	$ 237,762	$ 1,116,039

22. COMMITMENTS AND CONTINGENCIES

Legal Proceedings

In addition to the matters discussed below, we are or may also be subject to a variety of legal proceedings, alternative dispute resolution proceedings, governmental investigations, including SEC investigations, audits, claims and litigation, including claims under the False Claims Act and claims for benefits under insurance policies and claims by members, providers, customers, employees, regulators, investors and other third parties. In some cases, plaintiffs may seek punitive damages. It is not possible to accurately predict the outcome or estimate the resulting penalty, fine or other remedy that may result from any current or future legal proceeding, investigation, audit, claim or litigation. Nevertheless, the range of outcomes and losses could be significant and could have a material adverse effect on our consolidated financial statements.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

22. COMMITMENTS AND CONTINGENCIES (Continued)

On October 22, 2013, we filed a lawsuit in the United States District Court for the District of Delaware against funds affiliated with the private equity firm GTCR, known as GTCR, David Katz, a former managing director of GTCR, and former senior management of APS Healthcare. The lawsuit arose out of our acquisition of APS Healthcare from GTCR in March 2012.

On September 9, 2016, we entered into a Settlement Agreement with funds affiliated with GTCR and the other individual defendants to fully resolve all of the parties' respective outstanding claims arising from the Company's acquisition of APS Healthcare from GTCR in 2012.

Pursuant to the Settlement Agreement:

- We acquired all of the 6,272,104 shares of common stock held by the funds affiliated with GTCR and the other individuals for an aggregate payment of $13.0 million. In addition, we received $1.6 million that was held in an escrow account relating to the acquisition. GTCR received $749,000 that was held in such escrow account.

- George Sperzel, GTCR's designee on our board of directors, resigned from the Company's board of directors and the Letter Agreement dated as of March 2, 2012 between the Company and GTCR regarding board representation was terminated.

Governmental Regulation

Laws and regulations governing Medicare and other state and federal healthcare and insurance programs are complex and subject to significant interpretation. As part of the Affordable Care Act, known as ACA, CMS, State regulatory agencies and other regulatory agencies have been exercising increased oversight and regulatory authority over our Medicare and other businesses. Compliance with such laws and regulations is subject to CMS audit, other governmental review and investigation, including SEC investigations and significant and complex interpretation. CMS audits our Medicare Advantage plans with regularity to ensure we are in compliance with applicable laws, rules, regulations and CMS instructions. Our Medicare Advantage plans will likely be subject to audit in 2017. There can be no assurance that we will be found to be in compliance with all such laws, rules and regulations in connection with these audits, reviews and investigations, and at times we have been found to be out of compliance. Failure to be in compliance can subject us to significant regulatory action including significant fines, penalties, cancellation of contracts with governmental agencies or operating restrictions on our business, including, without limitation, suspension of our ability to market to and enroll new members in our Medicare plans, termination of our contracts with CMS, exclusion from Medicare and other state and federal healthcare programs and inability to expand into new markets or add new products within existing markets.

Certain of our subsidiaries provide products and services to various government agencies. As a government contractor, we are subject to the terms of the contracts we have with those agencies and applicable laws governing government contracts. As such, we may be subject to False Claim Act litigation (also known as qui tam litigation) brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government.

Lease Obligations

We are obligated under lease agreements for our corporate headquarters located in White Plains, New York as well as offices in Houston, Texas; and Syracuse, New York. In addition, we maintain other

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

22. COMMITMENTS AND CONTINGENCIES (Continued)

smaller offices to support our businesses. Rent expense was $4.4 million, $5.8 million, and $5.9 million for the years ended December 31, 2016, 2015 and 2014, respectively. Annual minimum rental commitments, subject to escalation, under non-cancelable operating lease (in thousands) are as follows:

2017	$ 4,531
2018	3,466
2019	1,886
2020	1,896
2021	1,680
Thereafter	386
Total	$ 13,845

23. BUSINESS SEGMENT INFORMATION

Our business segments are based on product and consist of

- Medicare Advantage; and
- MSO.

Our remaining segment, Corporate & Other, reflects the activities of our holding company, our prior participation in the New York Health Benefits Exchange, known as the Exchange, and other ancillary operations. Effective January 1, 2015, we are no longer participating in the Exchange. A description of our business segments is as follows:

Medicare Advantage—The Medicare Advantage segment contains the operations of our initiatives in managed care for seniors.

- HMO Plans: Our HMO plans are offered under contracts with CMS and provide all basic Medicare covered benefits with reduced member cost-sharing as well as additional supplemental benefits, including a defined prescription drug benefit. We built this coordinated care product around contracted networks of providers who, in cooperation with the health plan, coordinate an active medical management program.
- In connection with the HMOs, we operate separate Medicare Advantage Management Service Organizations that manage that business and affiliated Independent Physician Associations or IPAs. We participate in the net results derived from these affiliated IPAs.
- PPO Plans: Our PPO plans are offered under contracts with CMS and provide all basic Medicare covered benefits with reduced member cost-sharing as well as additional supplemental benefits, including a defined prescription drug benefit. This coordinated care product is built around contracted networks of providers who, in cooperation with the health plan, coordinate an active medical management program.
- PFFS Plans: Our PFFS plans are offered under contracts with CMS and provide enhanced health care benefits compared to traditional Medicare, subject to cost sharing and other limitations. These plans have limited provider network restrictions, which allow the members to have more flexibility in the delivery of their health care services than other Medicare Advantage

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

23. BUSINESS SEGMENT INFORMATION (Continued)

plans with limited provider network restrictions. Some of these products include a defined prescription drug benefit.

MSO—Our MSO segment supports our physician partnerships in the development of value-based healthcare models, such as ACOs, with a variety of capabilities and resources including technology, analytics, clinical care coordination, regulatory compliance and program administration. This segment includes our CHS subsidiary and affiliated ACOs. CHS works with physicians and other healthcare professionals to operate ACOs under the Medicare Shared Savings Program. CHS provides these ACOs with care coordination, analytics and reporting, technology and other administrative capabilities to enable participating providers to deliver better care and lower healthcare costs for their Medicare fee-for-service beneficiaries. The Company provides funding to CHS to support the operating activities of CHS and the ACOs.

We report intersegment revenues and expenses on a gross basis in each of the operating segments but eliminate them in the consolidated results. These intersegment revenues and expenses affect the amounts reported on the individual financial statement line items, but we eliminate them in consolidation and they do not change income before taxes. The most significant items eliminated relate to interest on intercompany loans which cross segments.

Financial data by segment, with a reconciliation of segment revenues and segment income (loss) before income taxes to total revenue and income (loss) from continuing operations before income taxes in accordance with U.S. generally accepted accounting principles is as follows:

	2016		2015		2014	
	Revenues	Income(Loss) Before Income Taxes	Revenues	Income(Loss) Before Income Taxes	Revenues	Income(Loss) Before Income Taxes
	(in thousands)					
Medicare Advantage	$ 1,376,409	$ 48,443	$ 1,256,035	$ 21,480	$ 1,410,324	$ 48,121
MSO	9	(9,487)	—	(20,058)	—	(30,809)
Corporate & Other	2,319	(37,331)	7,192	(40,287)	8,493	(49,378)
Intersegment revenues	(520)	—	(775)	—	(1,059)	—
Adjustments to segment amounts:						
Net realized gains (losses) (1)	1,429	1,429	38,954	38,954	(649)	(649)
Total	$ 1,379,646	$ 3,054	$ 1,301,406	$ 89	$ 1,417,109	$ (32,715)

(1) We evaluate the results of operations of our segments based on income (loss) before realized gains and losses and income taxes. Management believes that realized gains and losses are not indicative of overall operating trends.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

23. BUSINESS SEGMENT INFORMATION (Continued)

Identifiable assets by segment are as follows:

	December 31,		
	2016	2015	2014
		(in thousands)	
Medicare Advantage	$ 381,695	$ 355,363	$ 376,235
MSO	54,032	56,345	32,511
Corporate & Other	504,771	521,057	791,231
Assets of discontinued operations	229,814	1,150,570	1,378,501
Intersegment assets(1)	(384,729)	(352,473)	(477,977)
Total assets	$ 785,583	$ 1,730,862	$ 2,100,501

(1) Intersegment assets include the elimination of the parent holding company's investment in its subsidiaries as well as the elimination of other intercompany balances.

24. CONDENSED QUARTERLY RESULTS OF OPERATIONS (UNAUDITED)

The quarterly results of operations are presented below. Due to the use of weighted average shares outstanding when determining the denominator for earnings per share, the sum of the quarterly per common share amounts may not equal the full year per common share amounts.

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

24. CONDENSED QUARTERLY RESULTS OF OPERATIONS (UNAUDITED) (Continued)

2016

	For the Quarter Ended			
	December 31,	September 30,	June 30,	March 31,
	(in thousands)			
Total revenue, as previously reported	$ 340,882	$ 343,389	$ 346,082	$ 396,176
Less: revenue of discontinued operations	—	—	—	(46,883)
Total revenue	$ 340,882	$ 343,389	$ 346,082	$ 349,293
(Loss) income from continuing operations before income taxes	(23,572)	(9,262)	30,622	5,266
(Benefit from) provision for income taxes	(6,129)	(505)	12,241	3,737
(Loss) income from continuing operations	(17,443)	(8,757)	18,381	1,529
(Loss) income from discontinued operations, net of taxes	(1,060)	59,638	4,424	(1,336)
Net (loss) income	$ (18,503)	$ 50,881	$ 22,805	$ 193
(Loss) income per common share:				
Basic:				
(Loss) income from continuing operations	$ (0.31)	$ (0.14)	$ 0.22	$ 0.02
(Loss) income from discontinued operations	(0.02)	0.97	0.06	(0.02)
Net (loss) income	$ (0.33)	$ 0.83	$ 0.28	$ —
Diluted:				
(Loss) income from continuing operations	$ (0.31)	$ (0.14)	$ 0.22	$ 0.02
(Loss) income from discontinued operations	(0.02)	0.97	0.05	(0.02)
Net (loss) income	$ (0.33)	$ 0.83	$ 0.27	$ —

UNIVERSAL AMERICAN CORP. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

24. CONDENSED QUARTERLY RESULTS OF OPERATIONS (UNAUDITED) (Continued)

2015

	For the Quarter Ended			
	December 31,	September 30,	June 30,	March 31,
	(in thousands)			
Total revenue, as previously reported	$ 377,373	$ 339,790	$ 322,945	$ 355,520
Less: revenue of discontinued operations	(47,790)	—	—	(46,432)
Total revenue	$ 329,583	$ 339,790	$ 322,945	$ 309,088
(Loss) income from continuing operations before income taxes	(13,417)	12,996	12,777	(12,267)
(Benefit from) provision for income taxes	(3,833)	13,045	6,887	(12,314)
(Loss) income from continuing operations	(9,584)	(49)	5,890	47
(Loss) income from discontinued operations, net of taxes	(151,972)	2,857	(13,265)	2,107
Net (loss) income	$ (161,556)	$ 2,808	$ (7,375)	$ 2,154
Loss per common share:				
Basic:				
(Loss) income from continuing operations	$ (0.12)	$ —	$ 0.07	$ —
(Loss) income from discontinued operations	(1.84)	0.03	(0.16)	0.03
Net (loss) income	$ (1.96)	$ 0.03	$ (0.09)	$ 0.03
Diluted:				
(Loss) income from continuing operations	$ (0.12)	$ —	$ 0.07	$ —
(Loss) income from discontinued operations	(1.84)	0.03	(0.16)	0.03
Net (loss) income	$ (1.96)	$ 0.03	$ (0.09)	$ 0.03

Income from continuing operations for the quarters ended June 30 2016 and 2015 included our share of prior program year shared savings revenue from our ACOs, amounting to $29.8 million and $20.9 million, respectively. The quarter ended September 30, 2015 included $29.6 million in realized gains related to the sale of a cost-method investment.

Schedule I—Summary of Investments Other Than Investments in Related Parties
UNIVERSAL AMERICAN CORP.

Classification	December 31, 2016 Par Value	Amortized Cost	Fair Value	Carrying Value
		(in thousands)		
U.S. Treasury securities and obligations of U.S. Government	$ 22,350	$ 22,604	$ 21,961	$ 21,961
Government sponsored agencies	500	513	508	508
Other political subdivisions	24,075	25,726	25,664	25,664
Corporate debt securities	117,168	118,634	118,978	118,978
Foreign debt securities	31,285	32,006	31,248	31,248
Residential mortgage-backed securities	20,876	21,242	21,837	21,837
Commercial mortgage-backed securities	20,069	21,113	20,762	20,762
Other asset-backed securities	4,195	4,249	4,233	4,233
Sub-total	$ 240,518	$ 246,087	$ 245,191	245,191
Other invested assets				6,303
Total investments				$ 251,494

Classification	December 31, 2015 Par Value	Amortized Cost	Fair Value	Carrying Value
		(in thousands)		
U.S. Treasury securities and obligations of U.S. Government	$ 8,500	$ 8,481	$ 8,478	$ 8,478
Government sponsored agencies	500	516	507	507
Other political subdivisions	32,720	35,253	35,926	35,926
Corporate debt securities	143,385	144,772	146,423	146,423
Foreign debt securities	27,510	28,287	27,599	27,599
Residential mortgage-backed securities	34,423	34,973	35,969	35,969
Commercial mortgage-backed securities	20,658	21,264	21,151	21,151
Other asset-backed securities	5,652	5,731	5,723	5,723
Sub-total	$ 273,348	$ 279,277	$ 281,776	281,776
Other invested assets				9,734
Total investments				$ 291,510

Schedule II—Condensed Financial Information of Registrant

UNIVERSAL AMERICAN CORP.
(Parent Company)

CONDENSED BALANCE SHEETS
(in thousands)

	December 31, 2016	December 31, 2015
ASSETS		
Cash and cash equivalents	$ 102,879	$ 70,209
Investments in subsidiaries at equity	373,152	369,820
Income tax receivable	11,972	8,425
Other assets	6,600	7,762
Assets of discontinued operations	—	34,531
Total assets	$ 494,603	$ 490,747
LIABILITIES AND STOCKHOLDERS' EQUITY		
Loans from affiliates	$ —	$ 13,000
Convertible Senior Notes due 2021, net of fees	92,897	—
Series A mandatorily redeemable preferred shares, net of fees	39,939	39,755
Due to affiliates	29,146	23,420
Deferred income tax liability	39,552	17,283
Accounts payable and other liabilities	14,938	13,324
Dividends to stockholders—declared/unpaid	770	1,570
Liabilities of discontinued operations	7,948	—
Total liabilities	225,190	108,352
Total stockholders' equity	269,413	382,395
Total liabilities and stockholders' equity	$ 494,603	$ 490,747

See notes to condensed financial statements.

UNIVERSAL AMERICAN CORP.
(Parent Company)

CONDENSED STATEMENTS OF OPERATIONS

(in thousands)

	For the Years Ended December 31,		
	2016	2015	2014
REVENUES:			
Net investment income	$ 1,583	$ 2,127	$ 2,537
Realized gains on investments	—	87	897
Total revenues	1,583	2,214	3,434
EXPENSES:			
Selling, general and administrative expenses	32,796	36,498	37,131
Stock compensation expense	6,788	9,300	9,213
Interest expense	8,140	5,289	7,000
Total expenses	47,724	51,087	53,344
Loss before income tax benefit and equity in income of subsidiaries	(46,141)	(48,873)	(49,910)
Income tax benefit	(22,476)	(39,391)	(23,593)
(Loss) income before equity in earnings of subsidiaries	(23,665)	(9,482)	(26,317)
Equity in earnings (losses) of subsidiaries, net of taxes	17,375	5,786	(291)
Loss from continuing operations	(6,290)	(3,696)	(26,608)
Discontinued operations:			
Income (loss) from discontinued operations before income taxes	67,663	(188,371)	(1,210)
Provision for (benefit from) income taxes	5,997	(28,098)	1,649
Income (loss) from discontinued operations	61,666	(160,273)	(2,859)
Net income (loss)	$ 55,376	$ (163,969)	$ (29,467)

See notes to condensed financial statements.

UNIVERSAL AMERICAN CORP.
(Parent Company)

CONDENSED STATEMENTS OF CASH FLOWS

(in thousands)

	For the Years Ended December 31,		
	2016	2015	2014
	(in thousands)		
Cash flows from operating activities:			
Net income (loss)	$ 55,376	$ (163,969)	$ (29,467)
(Income) loss from discontinued operations	(61,666)	160,273	2,859
Loss from continuing operations	(6,290)	(3,696)	(26,608)
Adjustments to reconcile net income (loss) to net cash provided by (used for) operating activities:			
Equity in net (loss) income of subsidiaries	(17,375)	(5,786)	291
Realized gains on investments	—	(87)	(897)
Stock based compensation	6,788	9,300	9,213
Amortization of debt issuance costs	597	2,791	1,752
Amortization of discount on convertible notes	2,127	—	—
Change in amounts due to/from subsidiaries	5,726	32,557	2,355
Change in income taxes receivable	(3,547)	45,484	(14,823)
Deferred income taxes	15,353	(20,670)	10,829
Change in other assets and liabilities	(645)	(10,020)	11,311
Cash provided by (used for) operating activities of continuing operations	2,734	49,873	(6,577)
Cash provided by operating activities of discontinued operations	—	—	—
Cash provided by (used for) operating activities	2,734	49,873	(6,577)
Cash flows from investing activities:			
Proceeds from sale of fixed maturities	—	64,950	67,459
Cost of fixed maturity investments acquired	—	(60,570)	(18,311)
Net change in short-term investments	—	2,000	(2,000)
Capital contributions to subsidiaries	(9,000)	(26,400)	(34,000)
Dividends from subsidiaries	20,812	86,485	41,574
Other investing activities	—	2,778	275
Cash provided by investing activities of continuing operations	11,812	69,243	54,997
Cash provided by investing activities of discontinued operations	73,598	22,777	50,306
Cash provided by investing activities	85,410	92,020	105,303
Cash flows from financing activities:			
Net proceeds from issuance of common stock	(2,187)	95	(994)
Principal payment on loan from affiliates	(13,000)	(9,000)	—
Cost of share retirement	(151,271)	—	(36,180)
Proceeds from issuance of convertible notes	115,000	—	—
Payment of convertible notes issuance costs	(4,877)	—	—
Principal repayment on debt	—	(103,447)	—
Dividends to stockholders	861	(62,630)	(1,320)
Dividends from discontinued operations	73,598	22,777	50,306
Cash provided by (used for) financing activities of continuing operations	18,124	(152,205)	11,812
Cash used for financing activities of discontinued operations	(73,598)	(22,777)	(50,306)
Cash used for financing activities	(55,474)	(174,982)	(38,494)
Net increase (decrease) in cash and cash equivalents	32,670	(33,089)	60,232
Less: decrease in cash and cash equivalents from discontinued operations	—	—	—
Net increase (decrease) in cash and cash equivalents from continuing operations	32,670	(33,089)	60,232
Cash and cash equivalents:			
At beginning of year	70,209	103,298	43,066
At end of year	$ 102,879	$ 70,209	$ 103,298
Supplemental disclosure of cash flow information:			
Cash paid (received) during the year for:			
Interest	$ 5,814	$ 4,748	$ 6,609
Income taxes	$ (30,366)	$ (57,447)	$ 25,054

See notes to condensed financial statements.

UNIVERSAL AMERICAN CORP.
(Parent Company)

NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Except as otherwise indicated, references to the "Company," "Universal American," "we," "our," and "us" are to Universal American Corp., a Delaware corporation, and its subsidiaries.

Universal American is a specialty health insurance holding company with an emphasis on providing a broad array of health insurance and managed care products and services to people covered by Medicare.

In the parent company only financial statements, the parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition less dividends paid to the parent company by the subsidiaries. The parent company's share of net income of its wholly owned unconsolidated subsidiaries is included in its net loss income using the equity method. These parent company only financial statements should be read in conjunction with the Company's consolidated financial statements.

2. CONVERTIBLE SENIOR NOTES DUE 2021; STOCK REPURCHASE

On June 27, 2016, we completed an offering of $115.0 million of our 4.00% Convertible Senior Notes due 2021 (the "Convertible Notes"). The Convertible Notes are senior unsecured obligations of the Company. Interest on the Convertible Notes is payable on June 15 and December 15 of each year, commencing on December 15, 2016 until their maturity date of June 15, 2021. We may not redeem the Convertible Notes prior to the maturity date.

Prior to the close of the business day immediately preceding December 15, 2020, the Convertible Notes will be convertible only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on September 30, 2016 (and only during such calendar quarter), if the daily volume-weighted average price, or VWAP, of the common stock for at least 20 trading days (whether or not consecutive) during a period of thirty consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period after any five consecutive trading day period (the "measurement period") in which the trading price per $1,000 principal amount of notes for each trading day of the measurement period was less than 98% of the product of the daily VWAP of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. The Convertible Notes were not convertible at any time during the three month or nine month periods ended September 30, 2016 and did not result in any dilution in our calculation of earnings per share.

On or after December 15, 2020 until the close of business on the business day immediately preceding the maturity date, holders may convert their notes at any time, regardless of the foregoing circumstances. Upon conversion, we may satisfy our conversion obligation by paying or delivering, as applicable, cash, shares of our voting common stock, or a combination of cash and shares of voting common stock, at our election.

The Convertible Notes will be convertible at an initial conversion rate of 105.8890 shares of our voting common stock per $1,000 principal amount of the Convertible Notes, which is equivalent to an initial conversion price of approximately $9.44. The conversion rate will be subject to adjustment in certain events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will increase the conversion rate for a

UNIVERSAL AMERICAN CORP.
(Parent Company)

NOTES TO CONDENSED FINANCIAL STATEMENTS (Continued)

2. CONVERTIBLE SENIOR NOTES DUE 2021; STOCK REPURCHASE (Continued)

holder who elects to convert its notes in connection with such a corporate event in certain circumstances, including customary conversion rate adjustments in connection with a "make-whole fundamental change."

We allocated the principal amount of the Convertible Notes between its liability and equity components (see table below). The carrying amount of the liability component was determined by measuring the fair value of a similar debt instrument of similar credit quality and maturity that did not have the conversion feature. The carrying amount of the equity component, representing the embedded conversion option, was determined by deducting the fair value of the liability component from the principal amount of the Convertible Notes as a whole. The equity component was recorded to additional paid-in capital and is not remeasured as long as it continues to meet the conditions for equity classification. The excess of the principal amount of the Convertible Notes over the carrying amount of the liability component was recorded as a debt discount, and is being amortized to interest expense using an effective interest rate of 8.5% over the term of the Convertible Notes. We allocated the total amount of transaction costs incurred to the liability and equity components using the same proportions as the proceeds from the Convertible Notes. Transaction costs attributable to the liability component were recorded as a direct deduction from the liability component of the Convertible Notes, and are being amortized and recorded in other operating expenses using the effective interest method through the maturity date. Transaction costs attributable to the equity component were netted with the equity component of the Convertible Notes in additional paid-in capital.

The Convertible Notes consist of the following components (in thousands):

	December 31, 2016
Liability component:	
Principal	$ 115,000
Conversion feature	(20,637)
Amortization	2,127
Principal balance in liabilities	96,490
Liability portion of debt issuance costs	(3,593)
Net carrying amount	$ 92,897
Equity component:	
Conversion feature	$ 20,637
Equity portion of debt issuance costs	(875)
Deferred taxes	(6,917)
Net carrying amount	$ 12,845

We used the net proceeds from the Convertible Notes, together with cash on hand, to (i) repurchase all (a) 11,011,515 shares of our common stock held by certain affiliates of Perry and (b) 7,098,775 shares of our common stock held by certain affiliates of WCAS, at a purchase price of $6.80 per share, for an aggregate purchase price of approximately $123.0 million, and (ii) repurchase 2,082,800 shares of our common stock for an aggregate purchase price of approximately $15.1 million from purchasers of the convertible notes in privately negotiated transactions.

UNIVERSAL AMERICAN CORP.
(Parent Company)

NOTES TO CONDENSED FINANCIAL STATEMENTS (Continued)

2. CONVERTIBLE SENIOR NOTES DUE 2021; STOCK REPURCHASE (Continued)

We recognized interest expense on the Convertible Notes issued June 27, 2016 of $4.5 million for the year ended December 31, 2016, which included $2.1 million of non-cash interest expense, representing amortization of the discount on the carrying amount of the Convertible Notes.

Following the consummation of the WellCare Transaction, each holder of the Company's Convertible Notes that remain outstanding at such time will have the right to (i) convert its notes into the right to receive the merger consideration under the WellCare Transaction, which amount will be calculated using an increased conversion rate because the transaction will constitute a "Make-Whole Fundamental Change" under the terms of the notes, or (ii) require that the Company repurchase its notes, which repurchase shall be for the principal amount plus accrued interest and settled in cash. These conversion and repurchase rights will be exercisable during an approximately 30 day period specified by the Company following consummation of the WellCare Transaction.

3. MANDATORILY REDEEMABLE PREFERRED SHARES

On April 29, 2011, in conjunction with the sale of our Medicare Part D business, Universal American issued an aggregate of $40 million of Series A Mandatorily Redeemable Preferred Shares (the "Series A Preferred Shares"), representing 1,600,000 shares with a par value of $0.01 per share and a liquidation preference of $25.00 per share. The Series A Preferred Shares pay cash dividends at the rate of 8.5% per annum and are mandatorily redeemable on the six year anniversary of the issue date. There is no ability to call these securities before maturity except in the event of a change in control. The proceeds from the sale of the Series A Preferred Shares were used to pay a portion of the existing indebtedness of the Company prior to the sale and transaction expenses. We did not retain any proceeds from the sale of the Series A Preferred Shares. At the closing of the sale of our Medicare Part D business, certain officers and directors of the Company collectively purchased an aggregate of $10 million of the Series A Preferred Shares and we capitalized issue costs of approximately $1.1 million.

In accordance with ASC 480, Distinguishing Liabilities from Equity, because the issuance of the Series A Preferred Shares imposes an obligation on us requiring the transfer of assets, specifically, cash, at the redemption date, the Series A Preferred Shares are reported as a liability on the consolidated balance sheets, net of unamortized issue costs, with the related dividends reported as interest expense on the consolidated statements of operations. At December 31, 2016 and 2015 we had accrued $0.7 million of such dividends, recorded in other liabilities in the consolidated balance sheets.

Closing of the pending WellCare transaction would constitute a change in control with respect to the Series A Preferred Shares and would accelerate their settlement should the transaction close before the scheduled April 29, 2017 maturity of the Series A Preferred Shares.

4. LOANS FROM AFFILIATES

In the fourth quarter of 2013, we borrowed $13.0 million and $9.0 million, at an interest rate of 3.5%, payable quarterly, from our insurance company subsidiaries, Progressive and Pyramid, respectively, for general corporate purposes. On April 10, 2015, we repaid the outstanding balance of $9.0 million to Pyramid. On August 2, 2016, we repaid the outstanding balance of $13.0 million to Progressive.

UNIVERSAL AMERICAN CORP.
(Parent Company)

NOTES TO CONDENSED FINANCIAL STATEMENTS (Continued)

5. SPECIAL DIVIDEND

On October 26, 2015, we paid a special cash dividend of $0.75 per share, to shareholders of record on October 19, 2015. The total dividend was $63.0 million. This dividend is a liquidating dividend and was recorded as a reduction of additional paid-in capital.

A portion of each special cash dividend is recorded as a dividend payable liability expected to be paid in the future to holders of our restricted stock as such shares vest. This liability was $0.8 million and $1.6 million at December 31, 2016 and 2015, respectively, and is included in other liabilities in the consolidated balance sheets. In addition, pursuant to the terms of our 2011 Equity Award Plan, each dividend reduces the exercise price on outstanding stock options as of the ex-dividend date by the amount of the dividend.

Schedule III—SUPPLEMENTAL INSURANCE INFORMATION
UNIVERSAL AMERICAN CORP.
(in thousands)

	Policy and Contract Claims	Net Premiums Earned	Net Investment Income	Policyholder Benefits	Other Operating Expense
2016					
Medicare Advantage	$ 82,898	$ 1,366,716	$ 8,547	$ 1,153,829	$ 174,138
MSO	—	—	9	—	14,493
Corporate & Other	—	—	305	(2)	39,652
Intersegment and other adjustments	—	—	(267)	—	(520)
Segment Total	$ 82,898	$ 1,366,716	$ 8,594	$ 1,153,827	$ 227,763
2015					
Medicare Advantage	$ 86,976	$ 1,245,655	$ 9,435	$ 1,074,658	$ 159,897
MSO	—	—	—	—	10,431
Corporate & Other	—	316	3,067	(184)	47,665
Intersegment and other adjustments	—	—	(545)	—	(776)
Segment Total	$ 86,976	$ 1,245,971	$ 11,957	$ 1,074,474	$ 217,217
2014					
Medicare Advantage	$ 94,704	$ 1,393,444	$ 15,013	$ 1,171,002	$ 191,201
MSO	—	—	—	—	13,016
Corporate & Other	132	1,292	5,365	1,560	56,311
Intersegment and other adjustments	—	—	(790)	—	(1,059)
Segment Total	$ 94,836	$ 1,394,736	$ 19,588	$ 1,172,562	$ 259,469

Other required information was omitted because it was not applicable.

Universal American Corp.
Schedule V
Valuation and Qualifying Accounts

	Balance Jan 1	Charges/ (Recoveries) in Consolidated Statement of Operations	Write-offs Against Allowance	Acquisition and Other Adjs.	Balance Dec 31
			(in thousands)		
2016					
Advances to agents (1)	$ 32,176	$ (1,728)	$ (19,154)	$ —	$ 11,294
Other assets(2)	11,773	5,602	(1,398)	—	15,977
Valuation allowance for deferred taxes	36,897	(4,082)	—	(12,471)	20,344
2015					
Advances to agents (1)	$ 46,973	$ (2,754)	$ (12,043)	$ —	$ 32,176
Other assets(2)	19,277	6,926	(14,430)	—	11,773
Valuation allowance for deferred taxes	11,069	(156)	—	25,984	36,897
2014					
Advances to agents (1)	$ 56,985	$ (6,071)	$ (3,941)	$ —	$ 46,973
Other assets(2)	27,438	(369)	(7,792)	—	19,277
Valuation allowance for deferred taxes	7,217	3,726	—	126	11,069

(1) Amount reported as recoveries in the consolidated statement of operations represents advances to agents previously written off.

(2) Represents valuation account on receivables related to Medicare Advantage products.

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Section 2: EX-12.1 (EX-12.1)

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Exhibit 12.1

COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES

	2016	2015	2014	2013	2012
	(in thousands, except ratios)				
Pre-tax income (loss)—continuing operations	$ 3,054	$ 89	$ (32,715)	$ (16,149)	$ 56,569
Fixed charges					
Interest expense	$ 7,872	$ 4,743	$ 6,209	$ 6,496	$ 6,238
Amortization of debt costs	597	2,791	1,752	1,423	1,162
Imputed interest on rent expense	1,474	1,941	1,961	1,880	1,626
Total fixed charges	$ 9,943	$ 9,475	$ 9,922	$ 9,799	$ 9,026
Computation					
Total earnings and fixed charges	$ 12,997	$ 9,564	$ (22,793)	$ (6,350)	$ 65,595
Ratio of earnings to fixed charges(1)	1.31	1.01	—	—	7.27

(1) In 2014 and 2013, we incurred losses from continuing operations. As a result, our earnings were insufficient to cover our fixed charges by approximately $33 million and $16 million in 2014 and 2013, respectively.

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Exhibit 12.1

COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES
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Section 3: EX-21.1 (EX-21.1)

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Exhibit 21.1

List of Subsidiaries

Name	State of Incorporation
Accountable Care Coalition of Caldwell County, LLC	North Carolina
Accountable Care Coalition of Central Florida, LLC	Florida
Accountable Care Coalition of Central Georgia, LLC	Georgia
Accountable Care Coalition of Cherry Hill, LLC	New Jersey
Accountable Care Coalition of Chesapeake, LLC	Maryland
Accountable Care Coalition of Coastal Georgia, LLC	Georgia
Accountable Care Coalition of DeKalb, LLC	Georgia
Accountable Care Coalition of El Paso, LLC	Texas
Accountable Care Coalition of Eastern Wisconsin, LLC	Wisconsin
Accountable Care Coalition of Georgia, LLC	Georgia
Accountable Care Coalition of Greater Athens Georgia II, LLC	Georgia
Accountable Care Coalition of Greater Athens Georgia, LLC	Georgia
Accountable Care Coalition of Greater Augusta & Statesboro, LLC	Georgia
Accountable Care Coalition of Greater Houston, LLC	Texas
Accountable Care Coalition of Jacksonville, LLC	Florida
Accountable Care Coalition of Louisiana, LLC	Louisiana
Accountable Care Coalition of Maryland Primary Care, LLC	Maryland
Accountable Care Coalition of Maryland, LLC	Maryland
Accountable Care Coalition of Mississippi, LLC	Mississippi
Accountable Care Coalition of Mount Kisco, LLC	New York
Accountable Care Coalition of North Central Florida, LLC	Florida
Accountable Care Coalition of North Texas, LLC	Texas
Accountable Care Coalition of Northeast Georgia, LLC	Georgia
Accountable Care Coalition of Northwest Florida, LLC	Florida
Accountable Care Coalition of Northwest Georgia, LLC	Georgia
Accountable Care Coalition of South Carolina, LLC	North Carolina
Accountable Care Coalition of South Georgia, LLC	Georgia
Accountable Care Coalition of Southeast Texas, Inc.	Texas
Accountable Care Coalition of Southeast Wisconsin, LLC	Wisconsin
Accountable Care Coalition of Syracuse, LLC	New York
Accountable Care Coalition of Texas, Inc.	Texas
Accountable Care Coalition of the Green Mountains, LLC	Vermont
Accountable Care Coalition of the Tri-Counties, LLC	South Carolina
Accountable Care Coalition of the Wekiva Region, LLC	Florida
Accountable Care Coalition of Western Georgia, LLC	Georgia
American Progressive Life & Health Insurance Company of New York	New York
Ameri-Plus Preferred Care, Inc.	Florida
APS Healthcare Holdings, Inc.	Delaware

APS Healthcare, Inc.	Delaware
APS Parent, Inc.	Delaware
AWC of Syracuse, Inc.	New York
Chrysalis Medical Services, LLC	New Jersey
Collaborative Health Systems, LLC	New York
Collaborative Health Systems of Georgia, Inc.	Georgia
Collaborative Health Systems of Maryland, LLC	Maryland
Collaborative Health Systems of Virginia, LLC	Virginia
Empire Accountable Care, LLC	New York
Essential Care Partners, LLC	Texas
Georgia Statewide Accountable Care Coalition, LLC	Georgia

Name	State of Incorporation
Golden Triangle Physician Alliance	Texas
Heritage Health Systems of New York, Inc.	New York
Heritage Health Systems of Texas, Inc.	Texas
Heritage Health Systems, Inc.	Texas
Heritage Physician Networks	Texas
HHS Texas Management, Inc.	Georgia
HHS Texas Management, LP.	Georgia
Hudson Accountable Care, LLC	New York
Lone Star Accountable Care Coalition, LLC	Texas
Maine Community Accountable Care Organization, LLC	Maine
Maine Primary Care Holdings, LLC	Maine
Maryland Collaborative Care, LLC	Maryland
Mid-Atlantic Collaborative Care, LLC	Maryland
Northern Maryland Collaborative Care, LLC	Maryland
Penn Marketing America, LLC	Delaware
Premier Marketing Group, LLC	Delaware
Quincy Coverage Corporation	New York
SelectCare Health Plans, Inc.	Texas
SelectCare of Maine, Inc.	Maine
SelectCare of Texas, Inc.	Texas
TexanPlus Health Centers, LLC	Texas
Texas Physicians Collaborative, Inc.	Texas
Today's Options of Georgia, Inc.	Georgia
Today's Options of Texas, Inc.	Texas
UAM Agent Services Corp.	Iowa
UAM/APS Holding Corp.	Delaware
Universal American Financial Services, Inc.	Delaware
Universal American Holdings, LLC	Delaware
Virginia Collaborative Care, LLC	Virginia
Worlco Management Services, Inc. (NY)	New York
Worldnet Services Corp.	Florida

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Exhibit 21.1

List of Subsidiaries
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Section 4: EX-23.1 (EX-23.1)

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Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in Registration Statement on Form S-3 (No. 333-191075), Form S-8 (No. 333-173787), and Post-Effective Amendment on Form S-8 (No. 333-172691) of our reports dated February 28, 2017, relating to (1) the 2016 and 2015 consolidated financial statements and the financial statement schedules and the retrospective adjustments to the 2015 and 2014 consolidated financial statements of Universal American Corp. and subsidiaries (the "Company") (which report expresses an unqualified opinion and includes an explanatory paragraph regarding the definitive agreement between WellCare Health Plans, Inc. ("WellCare") and the Company under which WellCare will acquire the Company, as discussed in Note 1 to the consolidated financial statements (2) the effectiveness of the Company's internal control over financial reporting as of December 31, 2016, appearing in this Annual Report on Form 10-K of Universal American Corp. for the year ended December 31, 2016.

/s/ Deloitte & Touche LLP
New York, New York
February 28, 2017

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Exhibit 23.1

Consent of Independent Registered Public Accounting Firm
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Section 5: EX-23.2 (EX-23.2)

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Exhibit 23.2

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

1) Registration Statement (Form S-8 No. 333-173787) pertaining to the Universal American Corp. 2011 Omnibus Equity Award Plan,

2) Registration Statement (Post-Effective Amendment on Form S-8 No. 333-172691) pertaining to the old Universal American Corp. 1998 Incentive Compensation Plan,

3) Registration Statement (Form S-3 No. 333-191075) and related Prospectus of Universal American Corp. for the registration of 46,416,790 shares of its common stock;

of our report dated March 30, 2015, with respect to the consolidated financial statements and schedules of Universal American Corp. included in this Annual Report (Form 10-K) of Universal American Corp. for the year ended December 31, 2016.

/s/ ERNST & YOUNG LLP
New York, New York
February 28, 2017

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Exhibit 23.2

Consent of Independent Registered Public Accounting Firm
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Section 6: EX-31.1 (EX-31.1)

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Exhibit 31.1

CERTIFICATION

I, Richard A. Barasch, Chief Executive Officer of the registrant, certify that:

1. I have reviewed this annual report on Form 10-K of Universal American Corp.;

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

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

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

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

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

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

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

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

persons performing the equivalent functions):

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

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

Date: February 28, 2017

/s/ RICHARD A. BARASCH

Richard A. Barasch
Chief Executive Officer

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Exhibit 31.1

CERTIFICATION
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Section 7: EX-31.2 (EX-31.2)

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Exhibit 31.2

CERTIFICATION

I, Adam C. Thackery, Chief Financial Officer of the registrant, certify that:

1. I have reviewed this annual report on Form 10-K of Universal American Corp.;

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

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

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

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

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

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

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

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

persons performing the equivalent functions):

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

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

Date: February 28, 2017

/s/ ADAM C. THACKERY

Adam C. Thackery
Chief Financial Officer

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Exhibit 31.2

CERTIFICATION
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Section 8: EX-31.3 (EX-31.3)

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Exhibit 31.3

CERTIFICATION

I, David R. Monroe, Chief Accounting Officer of the registrant, certify that:

1. I have reviewed this annual report on Form 10-K of Universal American Corp.;

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

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

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

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

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

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

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

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

persons performing the equivalent functions):

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

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

Date: February 28, 2017

/s/ DAVID R. MONROE

David R. Monroe
Chief Accounting Officer

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Exhibit 31.3

CERTIFICATION
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Section 9: EX-32.1 (EX-32.1)

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Exhibit 32.1

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

In connection with the Annual Report on Form 10-K of Universal American Corp. (the "Registrant") for the year ended December 31, 2016, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), Richard A. Barasch, Chief Executive Officer of the Registrant, Adam C. Thackery, Chief Financial Officer of the Registrant and David R. Monroe, Chief Accounting Officer of the Registrant, each hereby certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to the best of his knowledge:

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

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

Date: February 28, 2017 /s/ RICHARD A. BARASCH

Richard A. Barasch
Chief Executive Officer

Date: February 28, 2017 /s/ ADAM C. THACKERY

Adam C. Thackery
Chief Financial Officer

Date: February 28, 2017 /s/ DAVID R. MONROE

David R. Monroe
Chief Accounting Officer

A signed original of this written statement required by Rule 13a-14(b) of the Securities Exchange Act of 1934 and 18 U.S.C. Section 1350 has been provided to the Registrant and will be retained by the Registrant and furnished to the Securities and Exchange Commission or its staff upon request.

This certification accompanies the Report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, and shall not be deemed filed with the Securities and Exchange Commission and is not to be incorporated by reference into any filing of the Registrant under the Securities Act of 1933 or the Securities Exchange Act of 1934 (whether made before or after the date of

the Form 10-K), irrespective of any general incorporation language contained in such filing.

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