Humana Health Plans of Puerto Rico, Inc.

(a wholly owned subsidiary of Humana Inc.)

Financial Statements
Statutory Basis of Accounting
December 31, 2022 and 2021

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Report of Independent Auditors

To the management and the Board of Directors of Humana Health Plan of Puerto Rico, Inc.

Opinions

We have audited the accompanying statutory basis statements of admitted assets, liabilities and surplus of Humana Health Plan of Puerto Rico, Inc. (the "Company"), as of December 31, 2022 and 2021, including the related notes (referred to as the "statutory basis statements of admitted assets, liabilities and surplus").

Unmodified Opinion on Statutory Basis of Accounting

In our opinion, the accompanying statutory basis statements of admitted assets, liabilities and surplus present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2022 and 2021, in accordance with the accounting practices prescribed or permitted by the Office of the Insurance Commissioner of the Commonwealth of Puerto Rico described in Note 2.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the accompanying statutory basis statements of admitted assets, liabilities and surplus do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2022 and 2021.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (US GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Statutory Basis Statements of Admitted Assets, Liabilities and Surplus section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the statutory basis statements of admitted assets, liabilities and surplus, the statutory basis statements of admitted assets, liabilities and surplus are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Office of the Insurance Commissioner of the Commonwealth of Puerto Rico, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the statutory basis statements of admitted assets, liabilities and surplus of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

Responsibilities of Management for the Statutory Basis Statements of Admitted Assets, Liabilities and Surplus

Management is responsible for the preparation and fair presentation of the statutory basis statements of admitted assets, liabilities and surplus in accordance with the accounting practices prescribed or permitted by the Office of the Insurance Commissioner of the Commonwealth of Puerto Rico. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of statutory basis statements of admitted assets, liabilities and surplus that are free from material misstatement, whether due to fraud or error.

In preparing the statutory basis statements of admitted assets, liabilities and surplus, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date the statutory basis statements of admitted assets, liabilities and surplus are available to be issued.

Auditors' Responsibilities for the Audit of the Statutory Basis Statements of Admitted Assets, Liabilities and Surplus

Our objectives are to obtain reasonable assurance about whether the statutory basis statements of admitted assets, liabilities and surplus as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with US GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the statutory basis statements of admitted assets, liabilities and surplus.

In performing an audit in accordance with US GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the statutory basis statements of admitted assets, liabilities and surplus, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the statutory basis statements of admitted assets, liabilities and surplus.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the statutory basis statements of admitted assets, liabilities and surplus.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Restriction of Use

This report is intended solely for the information and use of Management and the Board of Directors of the Company and the Department of State of the Commonwealth of Puerto Rico and is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP
Certified Public Accountants
(of Puerto Rico)
License No. LLP-216
Expires December 1, 2025

PricewaterhouseCoopers LLP

By: Luis F. Calderón
License No. 3874

San Juan, Puerto Rico
June 1, 2023

Humana Health Plans of Puerto Rico, Inc.
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2022 and 2021

	2022	2021
Admitted Assets		
Cash and invested assets		
Bonds	$ 90,967,750	$ 90,180,077
Total invested assets	90,967,750	90,180,077
Cash	19,232,160	36,436,963
Cash equivalents	185,160	197,898
Total cash and invested assets	110,385,070	126,814,938
Premiums receivable	19,548,840	26,078,543
Investment income due and accrued	533,033	420,374
Amounts receivable relating to uninsured plans	26,358,480	7,415,562
Health care and other receivables	5,654,362	7,034,675
Current income tax recoverable	-	259,825
Total admitted assets	$ 162,479,785	$ 168,023,917
Liabilities		
Benefits and loss adjustment expenses payable	$ 33,939,553	$ 38,660,241
Aggregate health policy reserves	9,179,469	32,104,840
Aggregate health claim reserves	36,014	28,677
Advance premiums	90,159	86,742
Accounts payable and accrued expenses	16,960,462	15,842,588
Income tax payable	231,482	-
Payable to affiliate	12,780,286	12,284,947
Total liabilities	73,217,425	99,008,035
Surplus		
Common stock, $5 par value; 1,000,000 shares authorized; 28,505 shares issued and outstanding	142,525	142,525
Paid-in surplus	62,787,516	62,787,516
Surplus notes	-	12,800,000
Required contingent reserve	(600,000)	(600,000)
Unassigned surplus/(Accumulated deficit)	26,932,319	(6,114,159)
Total surplus	89,262,360	69,015,882
Total liabilities and surplus	$ 162,479,785	$ 168,023,917

The accompanying notes are an integral part of these statutory basis financial statements.

1. Reporting Entity

Humana Health Plans of Puerto Rico, Inc. (the Company), a wholly owned subsidiary of Humana Inc. (Humana), is a health maintenance organization (HMO) in Puerto Rico domiciled in the Commonwealth of Puerto Rico and is authorized to sell health plan products therein. The Company is a federally-qualified HMO under Title XIII of the Public Health Service Act that is subject to the provisions of Chapter 19 of the Insurance Code of the Commonwealth of Puerto Rico (the Insurance Code) and to the regulations of the Office of the Insurance Commissioner of the Commonwealth of Puerto Rico (the Commissioner). Commonwealth regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 7, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 6.

The Company is under common management and ownership with Humana Insurance of Puerto Rico, Inc., an affiliated entity. The Company is managed and administered under a management agreement described in Note 8.

The Company has an agreement with the Puerto Rico Health Insurance Administration (PRHIA) to provide health insurance coverage to medically indigent qualifying individuals in the Medicare Platino Program (the Program). This agreement has been extended to December 31, 2023.

On January 30, 2015, the Company entered into an administrative services agreement with the MMM Holdings, LLC, PMC, Medicare Choice, LLC, MMM Multi Health, LLC and MSO of Puerto Rico. Under this agreement, the Company is providing access to the software used in executing the functionalities to support the managed care health insurance benefits being provided under the Government Health Plan Program within the Commonwealth of Puerto Rico. Per the terms of the agreement, the Company is being paid on a monthly basis with the income included within net other income (expense) in the accompanying statements of revenue and expenses.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 12(a).

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the Commissioner,

which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(m), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus/(accumulated deficit), whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus/(accumulated deficit), whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

v. Surplus notes issued to the Company are reported in surplus, whereas under GAAP, surplus notes are reported as liabilities;

vi. Administrative service fees received from customers on an uninsured basis are deducted from general administrative expenses, whereas under GAAP, these administrative fees are reported as revenue within the income statement;

vii. Comprehensive income disclosures required by GAAP are omitted; and

viii. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

ix. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The Commissioner adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The Commissioner has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. No deviations from the Codification currently exist.

b. Health Care Reform: Humana is and will continue to be regularly subject to new laws and regulations, changes to existing laws and regulations, and judicial determinations that impact the interpretation and applicability of those laws and regulations. The Health Care Reform Law (HCRL), the Families First Act, the CARES Act, and the Inflation Reduction Act, and related regulations, are examples of laws which have enacted significant reforms to various aspects of the U.S. health insurance industry, including, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage (MA) premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values, and changes to the Part D prescription drug benefit design.

It is reasonably possible that these laws and regulations, as well as other current or future legislative, judicial or regulatory changes (including further legislative or regulatory action taken in response to COVID-19) including restrictions on Humana's ability to manage its provider network or otherwise operate its business, or restrictions on profitability, including reviews by regulatory bodies that may compare its MA profitability to its non-M A business profitability, or compare the profitability of various products within its MA business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to Humana, or increases in regulation of its prescription drug benefit businesses, in the aggregate may have a material adverse effect on Humana's results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting Humana's ability to expand into new markets, increasing its medical and operating costs, further lowering its Medicare payment rates and increasing its expenses associated with assessments); its financial position; and its cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace these laws and regulations, including the HCRL or declare all or certain portions of these laws and regulations unconstitutional or contrary to law, create uncertainty for the Company's business, and the Company cannot predict when, or in what form, such legislative changes or judicial determinations may occur.

c. Cash and Cash Equivalents: The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. Investments: Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related

factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds, cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position for the years ended December 31, 2022 or December 31, 2021.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2022 or 2021.

For other restricted assets reported in aggregate, the pledged amounts with the Commissioner were $24,864,741 and $24,004,641, which is 14.44% and 13.62% of gross assets and 15.28% and 14.66% of net admitted assets, at December 31, 2022 and 2021, respectively. These investments, generally U.S. Treasury obligations, money market mutual funds, and certificates of deposit, were on deposit at December 31, 2022 and 2021 to satisfy requirements of regulatory

agencies. These assets are included in bonds and cash equivalents in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

e. Fair Value: In accordance with SSAP No. 100R, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

Level 1 Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include securities that are traded in an active exchange market.

Level 2 Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets and liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. Fair value of privately held investment grade debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held investment grade debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business with similar credit characteristics, and reviewing the underlying financial performance including estimating discounted cash flows. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price

fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2022 or 2021.

The Company did not have any financial assets carried at fair value in the accompanying statements of admitted assets, liabilities, and surplus as of December 31, 2021. The fair value of financial assets carried at fair value at December 31, 2022 were as follows:

	Fair Value Measurements at December 31, 2022			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Corporate debt securities	$ -	$ 2,860,188	$ -	$ 2,860,188
Total invested assets	$ -	$ 2,860,188	$ -	$ 2,860,188

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2022 and 2021 were as follows:

	December 31, 2022					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and cash equivalents	$ 81,574,946	$ 91,152,910	$ 185,160	$ 81,389,786	$ -	$ -

	December 31, 2021					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and cash equivalents	$ 90,654,725	$ 90,377,974	$ 197,897	$ 90,456,828	$ -	$ -

f. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other income in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from 3 to 10 years. Depreciation expense, including that related to the nonadmitted portion, was $1,291,624 and $1,259,939 for the years ended December 31, 2022 and 2021, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements,

including that related to the nonadmitted portion, was $481,084 and $486,644 for the years ended December 31, 2022 and 2021, respectively.

As noted in Note 2(a), certain assets designated as nonadmitted assets are excluded from the statements of admitted assets, liabilities and surplus by direct charges to (accumulated deficit)/unassigned surplus, whereas under GAAP, such amounts would be reported as assets. This includes the exclusion of equipment and improvements to lease facilities. As of the years ended December 31, 2022 and 2021, $4,943,326 and $7,088,173, respectively, of equipment and improvements to lease facilities net of accumulated depreciation of $9,188,869 and $7,364,404, respectively, was nonadmitted.

	2022		
	Statutory	Statutory Adjustments	GAAP
Book Value	$ -	$ 14,132,195	$ 14,132,195
Accumulated Depreciation	-	9,188,869	9,188,869
Net Book Value	$ -	$ 4,943,326	$ 4,943,326

	2021		
	Statutory	Statutory Adjustments	GAAP
Book Value	$ -	$ 14,452,574	$ 14,452,574
Accumulated Depreciation	-	7,364,401	7,364,401
Net Book Value	$ -	$ 7,088,173	$ 7,088,173

g. Income Taxes: The Company is subject to Commonwealth of Puerto Rico income taxes. Puerto Rico income tax on operating income is computed at the statutory income tax rates, which are progressive up to a maximum rate of 37.5%. The Company had an income tax expense of $1,949,557 and $801,851 for 2022 and 2021, respectively.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. As of December 31, 2022 $22,643,867 DTA was nonadmitted. As of December 31, 2021 no DTA was nonadmitted.

h. **Earned Premiums:** Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for its membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to account for certain demographic characteristics and health status of the Company's enrolled members. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data, collected from providers, to calculate the health status-related risk-adjusted premium payment to MA plans, which CMS further adjusts for coding pattern differences between the health plans and the government fee-for-service (FFS) program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's health status-adjusted payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, the Company conducts medical record reviews as part of its data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model.

The amount of net premiums written by the Company in 2022 and 2021 that were subject to retrospective rating features were $330,945,895 and $334,766,599, respectively, or 100.00% and 100.00%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $3,191,277 and $11,057,356 as of December 31, 2022 and 2021, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company recorded the following amounts at December 31, 2022 for policyholder rebates with no amounts recorded for December 31, 2021:

	2022					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred (recovered)	$ -	$ -	$ 1,144,090	$ 1,144,090	$ -	$ 1,144,090
Medical loss ratio rebates paid	-	-	-	-	-	-
Medical loss ratio rebates unpaid	-	-	1,144,090	1,144,090	-	1,144,090

The amounts recorded for the medical loss rebates incurred are recorded as a reduction of premium in earned premiums in the accompanying statutory statements of revenue and expenses. The medical loss rebates unpaid are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

There is no impact of any reinsurance assumed or ceded on the medical loss ratio rebate.

i. **Medicare Part D**: The Company covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments received monthly from CMS and members, which are determined from the Company's annual bid, represent amounts for providing prescription drug insurance coverage. The Company recognizes premiums revenue for providing this insurance coverage ratably over the term of its annual contract. The CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which the Company is not at risk.

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts

above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. The 2021 settlement with CMS did not occur in the current year.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2022 and 2021:

	2022		2021	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 11,791,626	$ -	$ 338,925	$ -
Amounts receivable relating to uninsured plans	-	26,348,551	-	7,415,562
Aggregate health policy reserves	(4,169,742)	-	(2,403,987)	-
Accounts payable and accrued expenses	-	(518,838)	-	(1,757,582)
Net asset (liability)	$ 7,621,884	$ 25,829,713	$ (2,065,062)	$ 5,657,980

j. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 8. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2022, 2021, and 2020:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days after Billing
12/31/2022	$ 5,309,465	$ 5,309,465	$ -	$ -	$ -
9/30/2022	5,381,265	5,724,928	5,697,983	-	-
6/30/2022	6,488,879	6,922,523	6,292,086	610,335	-
3/31/2022	6,135,383	4,271,326	2,784,838	655,457	830,468
12/31/2021	6,205,320	6,090,405	5,425,388	606,740	13,921
9/30/2021	6,777,754	6,742,994	6,388,201	332,294	11,720
6/30/2021	7,938,422	7,939,105	7,557,227	259,885	121,993
3/31/2021	7,540,720	6,919,222	6,906,890	-	12,332
12/31/2020	5,626,227	5,626,227	4,957,422	668,805	-
9/30/2020	7,783,342	7,783,342	7,736,025	43,462	3,855
6/30/2020	10,029,882	10,029,882	9,960,668	62,795	6,419
3/31/2020	8,408,542	8,408,542	8,235,371	173,171	-

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $103,117 and $147,082 were nonadmitted at December 31, 2022 and 2021, respectively.

k. Benefits Incurred and Loss Adjustment Expenses: Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for health care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. The Company also records benefits payable for future payments. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. The Company's reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally

require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $433,000 at December 31, 2021 but none were recorded at December 31, 2022. The liability at December 31, 2021 is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

l. **Administrative Service Only Contracts (ASO):** Administrative services fees cover the processing of claims, offering access to the Company's provider networks and clinical programs and responding to customer service inquiries from members of self-funded groups. Fees from providing administrative services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from Humana to cover catastrophic claims or to limit aggregate annual costs. The Company does not reflect payment of ASO claims in its statutory statements of revenue and expenses.

m. **Nonadmitted Assets:** Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, furniture and equipment, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus/(accumulated deficit) in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

n. **Going Concern Considerations:** Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). Based on this evaluation, management has

determined that there is no substantial doubt about the Company's ability to continue as a going concern.

o. Subsequent Events: The Company evaluated subsequent events through May 31, 2023, the date these financial statements were issued or available to be issued.

Humana announced on February 23, 2023 that it will be exiting the Employer Group Commercial Medical Products business, which includes all fully insured, self-funded and Federal Employee Health Benefit medical plans, as well as associated wellness and rewards programs. No other Humana health plan offerings are materially affected. Humana remains committed to the long-term growth of its core Insurance lines of business, including Medicare Advantage, Group Medicare, Medicare Supplement, Medicare Prescription Drug Plans, Medicaid, Military and Specialty (Dental, Vision, Life, etc.), as well as its CenterWell healthcare services business. Following a strategic review, Humana determined that the Employer Group Commercial Medical Products business was no longer positioned to sustainably meet the needs of commercial members over the long term or support the company's long-term strategic plans. The exit from this line of business will be phased over the next 18 to 24 months. Humana is committed to ensuring a smooth transition of services for members and commercial customers.

The Company is not aware of any other events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements, which may have a material effect on its financial condition.

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2022 and 2021 were as follows:

	2022			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 957,288	$ -	$ (8,897)	$ 948,391
All other governments	789,192	-	(152,497)	636,695
States, territories and possessions	-	-	-	-
Political subdivisions of states, territories and possessions	-	-	-	-
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	43,240,504	35,146	(4,590,323)	38,685,328
Industrial and miscellaneous	45,839,716	9,524	(4,870,917)	40,978,322
Hybrid securities	141,050	-	-	141,050
Total bonds	$ 90,967,750	$ 44,670	$ (9,622,634)	$ 81,389,786

	2021			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 1,615,546	$ -	$ (1,028)	$ 1,614,518
All other governments	389,444	806	(11,260)	378,990
States, territories and possessions	247,138	9,110	-	256,248
Political subdivisions of states, territories and possessions	354,656	11,831	-	366,487
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	40,639,123	262,161	(798,067)	40,103,217
Industrial and miscellaneous	46,519,170	1,114,122	(313,284)	47,320,008
Hybrid securities	415,000	3,010	(650)	417,360
Total bonds	$ 90,180,077	$ 1,401,040	$ (1,124,289)	$ 90,456,828

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2022, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 2,231,395	$ 2,220,098
Due after one year through five years	36,628,971	33,891,989
Due after five years through ten years	13,258,598	11,337,464
Due after ten years	4,728,080	3,647,954
Mortgage and asset-backed securities	34,120,706	30,292,281
	$ 90,967,750	$ 81,389,786

The detail of realized gains (losses) of bonds for the years ended December 31, 2022 and 2021 were as follows:

	2022	2021
Gross realized gains	$ 94,788	$ 450,362
Gross realized losses	(460,741)	(7,567)
Net realized (losses) gains	$ (365,953)	$ 442,795

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2022 and 2021 were as follows:

	2022					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 948,391	$ (8,897)	$ -	$ -	$ 948,391	$ (8,897)
All other governments	488,587	(99,681)	148,108	(52,816)	636,695	(152,497)
States, territories and possessions	-	-	-	-	-	-
Political subdivisions of states, territories and possessions	-	-	-	-	-	-
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	13,951,544	(960,052)	21,985,503	(3,630,271)	35,937,047	(4,590,323)
Industrial and miscellaneous	25,636,464	(2,464,398)	11,954,130	(2,406,519)	37,590,594	(4,870,917)
Hybrid securities	-	-	-	-	-	-
Total invested assets	$ 41,024,986	$ (3,533,028)	$ 34,087,741	$ (6,089,606)	$ 75,112,727	$ (9,622,634)

	2021					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 1,614,518	$ (1,028)	$ -	$ -	$ 1,614,518	$ (1,028)
All other governments	189,750	(11,260)	-	-	189,750	(11,260)
States, territories and possessions	-	-	-	-	-	-
Political subdivisions of states, territories and possessions	-	-	-	-	-	-
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	21,190,396	(530,896)	7,887,504	(267,171)	29,077,900	(798,067)
Industrial and miscellaneous	16,403,871	(272,446)	778,203	(40,838)	17,182,074	(313,284)
Hybrid securities	199,350	(650)	-	-	199,350	(650)
Total invested assets	$ 39,597,885	$ (816,280)	$ 8,665,707	$ (308,009)	$ 48,263,592	$ (1,124,289)

The unrealized loss from all debt securities was generated from 366 investment positions at December 31, 2022. All issuers of debt securities the Company owns that were trading at an unrealized loss at December 31, 2022 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2022, the Company did not intend to sell any debt securities with an unrealized loss position, and it is not likely that the Company will be required to sell these debt securities before recovery of their amortized cost basis. As a result, the Company believes that the debt securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2022.

Unrealized gains or losses on bonds at fair value deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Income Taxes

The Inflation Reduction Act (Act) was enacted on August 16, 2022 and included a new corporate alternative minimum tax (CAMT). The Act and the CAMT go into effect for tax years beginning after 2022. The Company has not determined as of December 31, 2022 if it will incur a CAMT liability in 2023. The annual financial statements do not include an estimated impact of the CAMT, because a reasonable estimate cannot be made. The Company has determined it will be an applicable corporation for 2023 as the average adjusted financial statement income for Humana Inc. and Subsidiaries exceeds the thresholds.

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2022 and 2021 were as follows:

	2022		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 22,643,867	$ 133,794	$ 22,777,661
Statutory valuation allowance adjustment	-	(133,794)	(133,794)
Adjusted gross deferred tax assets	22,643,867	-	22,643,867
Deferred tax assets nonadmitted	(22,643,867)	-	(22,643,867)
Subtotal net admitted deferred tax assets	-	-	-
Gross deferred tax liabilities	-	-	-
Net admitted deferred tax asset/(liability)	$ -	$ -	$ -

	2021		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 34,260,309	$ -	$ 34,260,309
Statutory valuation allowance adjustment	(34,260,309)	-	(34,260,309)
Adjusted gross deferred tax assets	-	-	-
Deferred tax assets nonadmitted	-	-	-
Subtotal net admitted deferred tax assets	-	-	-
Gross deferred tax liabilities	-	-	-
Net admitted deferred tax asset/(liability)	$ -	$ -	$ -

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2022 and 2021 were as follows:

	December 31, 2022		
	Ordinary	Capital	Total
Income taxes paid in prior years recoverable through loss carrybacks	$ -	$ -	$ -
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	-	-	-
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	-
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	13,389,354
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	-	-	-
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ -	$ -	$ -

	December 31, 2021		
	Ordinary	Capital	Total
Income taxes paid in prior years recoverable through loss carrybacks	$ -	$ -	$ -
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	-	-	-
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	-
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	-
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	-	-	-
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ -	$ -	$ -

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2022	2021
Ratio percentage used to determine recovery period and threshold limitation amount	1,306%	933%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 89,262,360	$ 69,015,882

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of income taxes incurred for the years ended December 31, 2022 and 2021 consisted of the following:

	2022	2021
Current year income tax provision	$ 1,859,529	$ 1,202,300
Revisions in prior years' estimated taxes	-	-
Income tax expense excluding the tax on realized capital gains and before change in net deferred income taxes	1,859,529	1,202,300
Change in deferred income tax	(22,643,867)	-
Correction of prior period error tax effect	-	-
Other, including prior year overaccrual	90,028	(400,449)
Total statutory income taxes	$ (20,694,310)	$ 801,851

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2022 and 2021 were as follows:

	2022	2021	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ -	$ 162,375	$ (162,375)
Advance premiums	-	-	-
Policyholder reserves	-	-	-
Investments	-	-	-
Deferred acquisition costs	-	-	-
Policyholder dividends accrual	-	-	-
Fixed assets	560,463	312,368	248,094
Compensation and benefit accruals	-	-	-
Pension accruals	-	-	-
Receivables - nonadmitted	3,562,184	4,802,139	(1,239,955)
Net operating loss carryforwards	12,321,020	23,285,558	(10,964,538)
Tax credit carryforward	-	-	-
Other	1,776,105	979,405	796,700
Bad debts	383,092	495,221	(112,129)
Accrued litigation	-	-	-
CMS Rx reserves	-	-	-
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	4,041,003	4,223,243	(182,240)
Accrued lease	-	-	-
Section 197 intangibles	-	-	-
Reinsurance Fee	-	-	-
Provider contracts	-	-	-
-	-	-	-
Gross ordinary DTAs	22,643,867	34,260,309	(11,616,442)
Statutory valuation allowance adjustment	-	(34,260,309)	34,260,309
Nonadmitted ordinary DTAs	(22,643,867)	-	(22,643,867)
Admitted ordinary DTAs	-	-	-
Capital			
Investments	133,794	-	133,794
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	133,794	-	133,794
Statutory valuation allowance adjustment	(133,794)	-	(133,794)
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ -	$ -	$ -

	2022	2021	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	-	-	-
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	-	-	-
CMS RX Reserve	-	-	-
Accrued Lease	-	-	-
-	-	-	-
Ordinary DTLs	-	-	-
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	-	-	-
Net deferred tax assets/(liabilities)	$ -	$ -	$ -

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. A statutory valuation allowance has been set up for deferred taxes on future capital loss items, due to uncertainty regarding the timing of their reversal.

The change in nonadmitted deferred tax assets from December 31, 2021 to 2022 was an increase of $22,643,867. There was no change in nonadmitted deferred tax assets recorded from December 31, 2020 to 2021.

The Company has net operating loss carryforwards of $32,856,043 and $62,094,822 at December 31, 2022 and 2021, respectively, expiring through 2030.

5. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2022 and 2021 are summarized as follows:

	2022	2021
Balance at January 1,	$ 38,660,241	$ 45,413,627
Health care receivables	(6,879,180)	(5,628,602)
Balance at January 1, net of health care receivables	31,781,061	39,785,025
Benefits incurred and loss adjustment expenses related to		
Current year	266,923,009	285,432,188
Prior year	(4,636,212)	(3,587,373)
	262,286,797	281,844,815
Benefits and loss adjustment expenses paid related to		
Current year	238,894,547	259,330,745
Prior year	26,565,790	30,518,034
	265,460,337	289,848,779
Balance at December 31,	33,939,553	38,660,241
Health care receivables	(5,332,032)	(6,879,180)
Balance at December 31, net of health care receivables	$ 28,607,521	$ 31,781,061

Benefits and loss adjustment expenses payable, net of healthcare receivables, as of December 31, 2021 were $31,781,061. As of December 31, 2022, $26,565,790 has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $579,059 as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been a $4,636,212 favorable prior-year development since December 31, 2021. The decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Included in this decrease, the Company experienced $4,567,919 of favorable prior year claim development on retrospectively rated policies. However, the business to which it relates is subject to premium adjustments.

The Company continually reviews data related to estimates of benefits and loss adjustment expenses payable recorded as of December 31, 2022. Based on current favorable development subsequent to year-end, the benefits and loss adjustment expenses payable at December 31, 2022 is $3,416,423 less than the amounts originally estimated.

6. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the Commissioner statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the Commissioner is the lesser of 10% of total surplus, or the greater of net operating gain for the calendar year preceding the dividend or for the 3 calendar years preceding the dividend less dividends paid for the most recent 2 of those calendar years. All ordinary dividends are limited to available and accumulated surplus funds. Based on these restrictions, no dividend was available without prior approval.

No dividends or returns of capital to shareholders were paid by the Company during the years ended December 31, 2022 or 2021.

7. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The Commonwealth of Puerto Rico has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $6,833,918 or the Company, under the discretion of the Commissioner of the Commissioner, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the Commonwealth of Puerto Rico which require a minimum capital and surplus level of $600,000 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $89,262,360 and $69,015,882 as of December 31, 2022 and 2021, respectively.

8. Related Party Transactions

The Company provides management and administrative services to Humana Insurance of Puerto Rico, Inc. (HIPR), an affiliate. The related expenses are allocated based on a number of factors depending on the specific expense. That is, certain expenses are allocated on a per member per month (PMPM) basis while others are allocated on a percentage of premium basis or other specific allocation basis. For the years ended December 31, 2022 and 2021, expenses allocated to HIPR from the Company amounted to $16,250,520 and $14,827,458, respectively, which are recorded as a reduction to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses.

The Company has a cash pooling arrangement with Humana whereby a majority of its cash is swept nightly. The Company reported $12,780,286 and $12,284,947 due to Humana associated with this arrangement and the aforementioned management arrangement with HIPR at December 31, 2022 and 2021, respectively, all of which was settled between the Company and Humana subsequent to both year ends and included in the statutory statements of assets, liabilities and surplus.

Pursuant to an agreement dated September 9, 1997, Humana has agreed to indemnify the Company for any health plan product obligation that the Company is unable to meet.

In the ordinary course of business, the Company has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(j) for further consideration of related pharmacy rebates. The Company had $127,984,695 and $113,830,180 of administrative service and prescription costs in 2022 and 2021, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(i).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $2,441,511 and $2,945,440 of prescription costs in 2022 and 2021, respectively, with Humana Pharmacy, Inc.

The Company received no capital contributions in the years ended December 31, 2022 or 2021.

9. Surplus Note

The Company issued a surplus note totaling $16,000,000 from an affiliated entity, HIPR in exchange for cash on December 31, 2018. The Company paid off the remaining surplus note in 2022 and the value at December 31, 2022 was $0. The carrying value as of December 31, 2021 was $12,800,000.

The Company accounted for the interest on its surplus note in accordance with SSAP No 41, *Surplus Notes*. Interest is not recorded as a liability nor an expense until approval for payment of such interest has been granted by the commissioner of the state of domicile. The Company received approval from the Commissioner on December 21, 2022 and paid on December 30, 2022. The interest was recorded as a reduction to Net Investment Income.

10. Employee Benefit Plans

The Company's employees are eligible to participate in the Humana Puerto Rico Retirement Savings Plan (the Plan), a defined contribution plan, sponsored by Humana. The Plan maintains two accounts, the Savings Account and the Retirement Account. The Company's total contributions paid to the Plan were $1,988,504 and $1,995,876 for the years ended December 31, 2022 and 2021, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses. As of December 31, 2022 and 2021, the fair market value of the Humana Puerto Rico Retirement Savings Plan's assets were $67,660,484 and $78,189,910, respectively.

11. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to three years. Operating lease rental payments charged to expenses for the years ended December 31, 2022 and 2021 was $1,495,751 and $1,495,423, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

Future minimum rental payments required under operating leases as of December 31, 2022, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2023	$	269,411
2024		150,294
2025		79,726
2026		-
2027		-
Thereafter		-
Total minimum lease payments	$	499,431

12. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $301,146,027 and $299,972,499 for the years ended December 31, 2022 and 2021, respectively. The loss of the Contracts (which are generally renewed annually) or significant changes in the Medicare Advantage and Prescription Drug Plan programs as a result of legislative or regulatory action, including changes to the Part D prescription drug benefit design or reductions in premium payments or, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2023, and all product offerings filed with CMS for 2023 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the BBA and BIPA, generally, pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to account for certain demographic characteristics and health status of the Company's enrolled members. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data, collected from providers, to calculate the health status-related risk-adjusted premium payment to MA plans, which CMS further adjusts for coding pattern differences between the health plans and the government fee-for-service (FFS) program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's health status-adjusted payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, the Company conducts medical record reviews as part of its data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model.

CMS and the Office of the Inspector General of Health and Human Services (HHS-OIG) perform audits of various companies' risk adjustment diagnosis data submissions. These audits are referred to herein as Risk-Adjustment Data Validation (RADV) audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices that influence the calculation of health status-related premium payments to MA plans.

In 2012, CMS released an MA contract-level RADV methodology that would extrapolate the results of each CMS RADV audit sample to the audited MA contract's entire health status-related risk adjusted premium amount for the year under audit. In doing so, CMS recognized "that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model (FFS claims)." To correct for this difference, CMS stated that it would apply a "Fee-for-

Service Adjuster (FFS Adjuster)" as "an offset to the preliminary recovery amount." This adjuster would be "calculated by CMS based on a RADV-like review of records submitted to support FFS claims data." CMS stated that this methodology would apply to audits beginning with PY 2011. Humana relied on CMS's 2012 guidance in submitting MA bids to CMS. Humana also launched a "Self-Audits" program in 2013 that applied CMS's 2012 RADV audit methodology and included an estimated FFS Adjuster. Humana completed Self-Audits for PYs 2011-2016 and reported results to CMS.

As of December 31, 2021, the Company performed internal contract level audits based on the RADV audit methodology prescribed by CMS, and estimated audit settlements were recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company completed these audits for payment years 2011-2016. Included in these internal contract level audits was an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which had not yet been finalized as of December 31, 2021. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits. Estimates derived from these results indicated a potential exposure of approximately $25 million as of December 31, 2021 which was included in aggregate health policy reserves in the statutory statements of admitted assets, liabilities and surplus. During 2022, the Company released these reserves, which resulted in an increase to earned premiums in the statutory statements of revenue and expenses. The reserve release was recorded in 2022 since the Company deemed these liabilities were no longer needed.

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

Humana is considering its legal options with respect to CMS's changed position on the FFS Adjuster and seeking clarity regarding its compliance obligations in light of the Final RADV Rule. Humana believes that the Final RADV Rule fails to address adequately the statutory requirement of actuarial equivalence. Further, Humana's actuarially certified bids through 2023 preserved Humana's position that CMS should apply a FFS Adjuster in any RADV audit that CMS intends to extrapolate. Humana expects CMS to apply the Final RADV Rule, including the first application of extrapolated audit results to determine audit settlements without a FFS Adjuster, to CMS and HHS-OIG RADV audits conducted for 2018 and subsequent years. The Final RADV Rule, including the lack of a FFS Adjuster, and any related regulatory, industry or company reactions, could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS that may, either

individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus or cash flows.

As Humana explores its legal options and compliance obligations, it remains committed to working alongside CMS to promote the integrity of the MA program as well as affordability and cost certainty for its members. It is critical that MA plans are paid accurately and that payment model principles, including the application of a FFS Adjuster, are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

The achievement of star ratings of 4-star or higher qualifies MA plans for premium bonuses. The Company's MA plans' operating results may be significantly affected by their star ratings. Despite the Company's operational efforts to improve its star ratings, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. In addition, audits of the Company's performance for past or future periods may result in downgrades to its star ratings. Accordingly, the Company's plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

b. **COVID-19:** The emergence and spread of the novel coronavirus, or COVID-19, beginning in the first quarter of 2020 has impacted the Company's business. During periods of increased incidences of COVID-19, a reduction in non-COVID-19 hospital admissions for non-emergent and elective medical care have resulted in lower overall healthcare system utilization. At the same time, COVID-19 treatment and testing costs increased utilization. During 2022, the Company experienced lower overall utilization of the healthcare system than anticipated, as the reduction in COVID-19 utilization following the increased incidence associated with the Omicron variant outpaced the increase in non-COVID-19 utilization. The significant disruption in utilization during 2020 also impacted the Company's ability to implement clinical initiatives to manage health care costs and chronic conditions of its members, and appropriately document their risk profiles, and, as such, affected 2021 revenue under the risk adjustment payment model for MA plans. Finally, changes in utilization patterns and actions taken in 2021 as a result of the COVID-19 pandemic, including the suspension of certain financial recovery programs for a period of time and shifting the timing of claim payments and provider capitation surplus payments, impacted claim reserve development and operating cash flows for 2021.

c. **Legal Proceedings:** During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus and cash flows, and may also affect the Company's reputation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided Humana's legal counsel with an information request concerning Humana's Medicare

Part C risk adjustment practices. The request relates to Humana's oversight and submission of risk adjustment data generated by providers in its MA network, as well as to its business and compliance practices related to risk adjustment data generated by its providers and by Humana, including medical record reviews conducted as part of its data and payment accuracy compliance efforts, the use of health and well-being assessments, and fraud detection efforts. Humana believes that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of MA plans, providers and vendors. Humana cooperated with the Department of Justice, and has not heard from the Department of Justice on this matter since 2020.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned *United States of America ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by Humana in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by it under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. Humana has substantially completed discovery with the relator who has pursued the matter on behalf of the United States following its unsealing. On March 31, 2022, the Court denied the parties' Motions for Summary Judgement. Humana takes seriously its obligations to comply with applicable CMS requirements and actuarial standards of practice, and continues to vigorously defend against these allegations.

d. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

The Puerto Rico economy continues to experience a period of slow economic growth and high unemployment, further exacerbated by Hurricane Maria. The Company has closely monitored the impact that this volatile economy is having on its operations. Workforce reductions have caused corresponding membership losses in fully-insured commercial group business. Continued weakness in the Puerto Rico economy, and any continued high unemployment, may materially adversely affect the Company's membership.

Additionally, the continued weakness of the Puerto Rico economy has adversely affected its budget. This could result in attempts to reduce payments in the Company's Commonwealth government health care coverage program, and could result in an increase in taxes and assessments on its activities. The Company's Medicare program is always subject to funding changes. The Company cannot predict the future funding levels of, or other such changes to, these programs. Although the Company could attempt to mitigate or cover its exposure from increased costs through, among other things, increases in premiums, there can be no assurance that the Company will be able to mitigate or cover all of such costs which may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus, and cash flows.

e. Securities & Credit Markets Risks: Ongoing volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or credit related impairments may be recorded in future periods.

f. Guarantee: The Company has a parental guarantee with Humana if the Company is unable to comply with regulatory requirements.

13. Uninsured Plans

Information for the year ended December 31, 2022 regarding the profitability of ASO plans and the uninsured portion of partially insured plans for which the Company provides administrative services were as follows:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	$ (257,116)	$ -	$ (257,116)
Total net other income or expenses (including interest paid to or received from plans)	3,826,507	-	3,826,507
Net gain from operations	$ 3,569,391	$ -	$ 3,569,391
Total claim payment volume	-	-	-

As of December 31, 2022, the Company has recorded a receivable from CMS of $26,348,551 related to the cost share and reinsurance components of administered Medicare products. The Company does not have any receivables greater than 10% of the Company's accounts receivable from uninsured accident and health plans or $10,000.