and supplemental health, life and accident) are now reported as follows:

- substantially all of the international health care business (comprised primarily of the global health benefits business) is now reported with the former Health Care segment and renamed ***Global Health Care***; and
- the supplemental health, life and accident business becomes a separate reporting segment named ***Global Supplemental Benefits***.

As a result of these changes, the financial results of Cigna's businesses are now reported in the following segments:

- Global Health Care aggregates the following two operating segments:
  - Commercial (including the international health care business)
  - Government
- Group Disability and Life
- Global Supplemental Benefits
- Run-off Reinsurance and
- Other Operations, including Corporate-owned Life Insurance.

Prior year segment information has been conformed to the new segment structure.

Significant Factors Affecting the Company

For information on the Company's business strategy, see the "Description of Business" section of this Form 10-K beginning on page 1. The Company's ability to increase revenue, shareholders' net income and operating cash flows from ongoing operations is directly related to progress in executing its strategy as well as other key factors, including the Company's ability to:

- profitably underwrite and price products and services at competitive levels that manage risk and reflect emerging experience;
- cross sell its various health and related benefit products;
- invest available cash at attractive rates of return for appropriate durations; and
- effectively deploy capital.

In addition to the Company-specific factors cited above, overall results are influenced by a range of economic and other factors, especially:

- cost trends and inflation for medical and related services;
- utilization patterns of medical and other services;
- employment levels;
- the tort liability system;
- developments in the political environment both domestically and internationally, including U.S. Health Care Reform;
- interest rates, equity market returns, foreign currency fluctuations and credit market volatility, including the availability and cost of credit in the future;
- Medicare reimbursement rates issued by the Centers for Medicare and Medicaid Services ("CMS"), including the bonus structure based on CMS performance ratings; and
- federal, state and international regulation.

The Company regularly monitors the trends impacting operating results from the above mentioned key factors to appropriately respond to economic and other factors affecting its operations, both in its ongoing and run-off operations.

Run-off Operations

As of December 31, 2012 the Company's run-off reinsurance operations had significant exposures, primarily from its guaranteed minimum death benefits ("GMDB", also known as "VADBe") and guaranteed minimum income benefits ("GMIB") products. Effective February 4, 2013, the Company entered into an agreement to reinsure 100% of the Company's future exposures for these businesses, net of retrocessional arrangements in place prior to February 4, 2013, up to a specified limit. See Note 25 to the Consolidated Financial Statements for additional information.

Health Care Reform

In the first quarter of 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act ("Health Care Reform") were signed into law. Certain of the law's provisions are already effective while others will take effect from 2013 to 2018. The Company has implemented the provisions of Health Care Reform that are currently in effect (including the commercial minimum medical loss ratio requirements) and continues its implementation planning for those provisions that must be adopted in the future. Management is currently unable to estimate the full impact of Health Care Reform on the Company's future results of operations, and its financial condition and liquidity due to uncertainties related to interpretation, implementation and timing of its many provisions as well as the potential for the law to be amended. It is possible, however, that certain provisions of Health Care Reform could have a material impact on future results of operations.

Commercial minimum medical loss ratio requirements became effective in January 2011, requiring payment of premium rebates beginning in 2012 to employers and customers covered under the Company's comprehensive commercial medical insurance plans if certain annual minimum loss ratios are not met. The Company recorded its rebate accrual based on estimated medical loss ratios calculated as prescribed by the U.S. Department of Health and Human Services ("HHS") using full-year premium and claim information by state and market segment for each legal entity that issues comprehensive medical insurance. HHS regulations permit adjustments to be made to the claims used in the calculation for Cigna's international health care and limited benefits plans subject to the MLR minimums. The adjustments for limited benefit plans are only allowed through 2014. In 2012, the Company accrued an estimated rebate of $37 million pre-tax ($24 million after-tax), compared with an accrual of $63 million pre-tax ($41 million after-tax) in 2011. The Company paid $77 million in 2012, slightly higher than the estimated rebate accrual of $63 million, primarily due