

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)



**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2023

OR



**TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____
Commission file number: 001-16751



ELEVANCE HEALTH, INC.

(Exact name of registrant as specified in its charter)

Indiana

(State or other jurisdiction of
incorporation or organization)

35-2145715

(I.R.S. Employer Identification Number)

220 Virginia Avenue

Indianapolis, Indiana 46204

(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: (833) 401-1577

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading symbol(s)	Name of each exchange on which registered
Common Stock, Par Value \$0.01	ELV	New York Stock Exchange

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	<input checked="" type="checkbox"/>	Accelerated filer	<input type="checkbox"/>
Non-accelerated filer	<input type="checkbox"/>	Smaller reporting company	<input type="checkbox"/>
Emerging growth company	<input type="checkbox"/>		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b) ☐

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all directors and executive officers of the registrant are "affiliates") as of June 30, 2023 was approximately \$104,634,460,663.

As of February 1, 2024, 232,668,735 shares of the registrant's common stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 15, 2024.

Elevance Health, Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2023

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References in this Annual Report on Form 10-K to the terms “we,” “our,” “us,” “Elevance Health” or the “Company” refer to Elevance Health, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the term “states” include the District of Columbia and Puerto Rico, unless the context otherwise requires.

FORWARD-LOOKING STATEMENTS

This document contains certain forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements reflect our views about future events and financial performance and are generally not historical facts. Words such as “expect,” “feel,” “believe,” “will,” “may,” “should,” “anticipate,” “intend,” “estimate,” “project,” “forecast,” “plan” and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various risks and other disclosures discussed in our reports filed with the U.S. Securities and Exchange Commission from time to time, which attempt to advise interested parties of the factors that affect our business. Except to the extent required by law, we do not update or revise any forward-looking statements to reflect events or circumstances occurring after the date hereof. These risks and uncertainties include, but are not limited to: trends in healthcare costs and utilization rates; reduced enrollment; our ability to secure and implement sufficient premium rates; the impact of large scale medical emergencies, such as public health epidemics and pandemics, including COVID-19, and other catastrophes; the impact of new or changes in existing federal, state and international laws or regulations, including laws and regulations impacting healthcare, insurance, pharmacy services and other diversified products and services, or their enforcement or application; the impact of cyber-attacks or other privacy or data security incidents or breaches or our failure to comply with any privacy, data or security laws or regulations, including any investigations, claims or litigation related thereto; information technology disruptions; changes in economic and market conditions, as well as regulations that may negatively affect our liquidity and investment portfolios; competitive pressures and our ability to adapt to changes in the industry and develop and implement strategic growth opportunities; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon; our ability to maintain and achieve improvement in Centers for Medicare and Medicaid Services Star ratings and other quality scores and funding risks with respect to revenue received from participation therein; a negative change in our healthcare product mix; costs and other liabilities associated with litigation, government investigations, audits or reviews; our ability to contract with providers on cost-effective and competitive terms; failure to effectively maintain and modernize our information systems; risks associated with providing healthcare, pharmacy and other diversified products and services, including medical malpractice or professional liability claims and non-compliance by any party with the pharmacy services agreement between us and CaremarkPCS Health, L.L.C.; risks associated with mergers, acquisitions, joint ventures and strategic alliances; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; possible restrictions in the payment of dividends from our subsidiaries and increases in required minimum levels of capital; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; the potential negative effect from our substantial amount of outstanding indebtedness and the risk that increased interest rates or market volatility could impact our access to or further increase the cost of financing; a downgrade in our financial strength ratings; the effects of any negative publicity related to the health benefits industry in general or us in particular; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; intense competition to attract and retain employees; risks associated with our international operations; and various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations.

PART I

ITEM 1. BUSINESS.

General

Elevance Health and its subsidiaries, referred to throughout this document as “we,” “us,” “our,” the “Company” or “Elevance Health,” is a leading health company bringing together the concepts of elevate and advance, in order to exemplify and follow our bold purpose of improving the health of humanity. We serve people across their entire health journey to better address their full range of needs with an integrated whole-health approach. Through our broad view, we aim to meaningfully improve the health of the people and communities we serve. We strive to deliver on our mission by maximizing the power of partnerships, innovating to fuel growth and health equity, and maintaining a high-performance culture. Our strategy is to be a lifetime trusted health partner through the following four core focus areas:

- *Whole Health* – Partner to address physical, behavioral and social needs to improve health, affordability, quality, equity, and access for individuals and communities.
- *Exceptional Experiences* – Put the consumers we serve at the center of all that we do, personalizing engagement to meet consumers where they are and optimize health outcomes across individuals and populations.
- *Care Provider Enablement* – Be the easiest payer to work with by supporting care provider partners with data, insights, and tools they need to deliver exceptional care for our consumers.
- *Digital Platform* – Use digital technologies such as AI to transform the way we operate our business and interact with consumers by driving improvements in efficiency and experiences and converting data into actionable insights.

With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

- *Community* – We put people first
- *Diversity* – We value our differences
- *Integrity* – We build trust
- *Agility* – We embrace change
- *Leadership* – We lead by example

We are one of the largest health insurers in the United States in terms of medical membership, serving approximately 47 million medical members through our affiliated health plans as of December 31, 2023. We offer a broad spectrum of network-based managed care risk-based plans to Individual, Employer Group, Medicaid and Medicare markets. In addition, we provide a broad array of managed care services to fee-based customers, including claims processing, stop loss insurance, provider network access, medical management, care management, wellness programs, actuarial services and other administrative services. We provide services to the federal government in connection with our Federal Health Products & Services business, which administers the Federal Employees Health Benefits (“FEHB”) Program. We provide an array of specialty services both to customers of our subsidiary health plans and also to unaffiliated health plans, including pharmacy services, dental, vision, life, disability and supplemental health insurance benefits, as well as integrated health services.

We are an independent licensee of the Blue Cross and Blue Shield Association (“BCBSA”), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield (“BCBS”) licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross and Anthem Blue Cross and Blue Shield. We also conduct business through arrangements with other BCBS licensees, as well as other strategic partners. In addition, we serve members in numerous states as Amerigroup, Freedom Health, HealthSun, MMM, Optimum Healthcare, Simply Healthcare and/or Wellpoint. We are licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through our subsidiaries. Through various subsidiaries, we also offer pharmacy services through our CaredonRx business, and other healthcare related services as Caredon Insights, Caredon Health, Caredon Behavioral Health and CareMore.

As we announced in 2022, we are organizing our brand portfolio into the following core go-to-market brands:

- Anthem Blue Cross/Anthem Blue Cross and Blue Shield — represents our existing Anthem-branded and affiliated Blue Cross and/or Blue Shield licensed plans;
- Wellpoint — we are uniting select non-BCBSA licensed Medicare, Medicaid and commercial plans under the Wellpoint name; and
- Carelon — this brand brings together our healthcare related services and capabilities, including our CarelonRx and Carelon Services businesses, under a single brand name.

Our branding strategy reflects the evolution of our business from a traditional health insurance company to a lifetime, trusted health partner. Given this evolution, we reviewed and modified how we manage our business, monitor our performance and allocate resources, and made changes to our reportable segments beginning in the first quarter of 2023. We now report our results of operations in the following four reportable segments: Health Benefits (aggregates our previously reported Commercial & Specialty Business and Government Business segments), CarelonRx, Carelon Services (previously included in our Other segment) and Corporate & Other (our businesses that do not individually meet the quantitative thresholds for an operating segment, as well as corporate expenses not allocated to our other reportable segments). During the fourth quarter of 2023, we moved our Carelon Global Solutions international businesses from the Corporate & Other reportable segment to the Carelon Services reportable segment. All prior period reportable segment information has been reclassified for comparability to conform to the current presentation.

For additional discussion, see “Reportable Segments” below in this “Business” section and Note 1, “Organization,” and Note 20, “Segment Information,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We believe healthcare is local and that we have the strong local presence required to understand and meet local customer needs with regard to any product customers are enrolled in with us. Further, we believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and healthcare professionals. Ultimately, we believe that practical and sustainable improvements in healthcare must focus on improving healthcare quality while managing costs for total affordability. We have implemented initiatives driving payment innovation and partnered with providers to lower cost and improve the quality of healthcare for our members, and we continue to develop new and innovative ways to effectively manage risk and engage our members. Further, we continue to expand our financial arrangements with providers to implement payment models that advance value-based care. We believe focusing on quality of care rather than volume of care is the foundation for improving patient outcomes. Our value-based payment model supports patient-centered care by improving collaboration between providers and health partners and delivering to our patients the right care, at the right time, in the right place. In addition, we are focused on achieving efficiencies from our national scale while optimizing service performance for our customers. Finally, we expect to continue to rationalize our portfolio of businesses and products and align our investments to optimize our core businesses, invest in high-growth opportunities, and accelerate capabilities and services.

Impact on Our Results of Operations

Our results of operations depend in large part on our ability to accurately predict and effectively manage healthcare costs through effective contracting with providers of care to our members, product pricing, medical management and health and wellness programs, including service coordination and case management for addressing complex and specialized healthcare needs, innovative product design and our ability to maintain or achieve improvement in our Centers for Medicare and Medicaid Services (“CMS”) Star ratings. CMS Star ratings affect Medicare Advantage plan reimbursements as well as our eligibility to earn quality-based bonus payments for those plans. See “Regulation” below in this “Business” section for additional information on our CMS Star ratings. For additional information on our networks and provider relations, product pricing and healthcare cost management programs, see “Pricing and Underwriting of Our Products,” “Networks and Provider Relations,” “Medical Management Programs,” “Care Management and Wellness Products and Programs” and “Healthcare Quality Initiatives” below in this “Business” section.

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

Our future results of operations will be impacted by certain external forces and resulting changes in our business model and strategy. Changes to our business environment will continue as elected officials at the national and state levels enact, and both elected officials and candidates for election propose, modifications to existing laws and regulations, including changes to taxes and fees. For additional discussion, see “Regulation” below in this “Business” section and Part I, Item 1A “Risk Factors” included in this Annual Report on Form 10-K.

Our results of operations are also impacted by levels and mix of membership, which can change as a result of the quality and pricing of our health benefits products and services, an aging population, economic conditions, changes in unemployment, the continued and future impact of large-scale emergencies like the COVID-19 pandemic, acquisitions, entry into new markets and expansions in or exits from existing markets. These membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes, membership impacts caused by Medicaid redeterminations, changes in how our members access healthcare services, or our exit from a specific market. See Part I, Item 1A “Risk Factors” and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in this Annual Report on Form 10-K.

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

Through our participation in various federal government programs, we generated approximately 29% of our total consolidated revenues from agencies of the U.S. government for the year ended December 31, 2023 and 28% for the years ended December 31, 2022 and 2021, respectively. The majority of these revenues are contained in our Health Benefits segment as described below. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S. and Puerto Rico.

Reportable Segments

In 2022, we managed and presented our operations through the following four reportable segments: Commercial & Specialty Business, Government Business, CarelonRx and Other. In the first quarter of 2023, we reorganized our reportable segments as described below. Previously reported information in this Annual Report on Form 10-K has been reclassified to conform to the new presentation and reflect changes that occurred in 2023.

Our Health Benefits segment offers a comprehensive suite of health plans and services to our Individual, Employer Group risk-based, Employer Group fee-based, BlueCard®, Medicare, Medicaid and FEHB program members. Our Health Benefits segment also includes our National Government Services business. The Health Benefits segment offers health products on a full-risk basis; provides a broad array of administrative managed care services to our fee-based customers; and provides a variety of specialty and other insurance products and services such as stop loss, dental, vision, life, disability and supplemental health insurance benefits.

Our CarelonRx segment includes our pharmacy business. CarelonRx markets and offers pharmacy services, including pharmacy benefit management (“PBM”) services, to our affiliated health plan customers, as well as to external customers outside of the health plans we own. CarelonRx offers a comprehensive pharmacy services portfolio, which includes all core

pharmacy services, such as home delivery and specialty pharmacies, claims adjudication, formulary management, pharmacy networks, rebate administration, a prescription drug database and member services.

Our Carelon Services segment integrates physical, behavioral, social and pharmacy services to deliver whole health affordably by creating value through the offering of market-competitive services powered by analytics. Carelon Services offers a broad array of healthcare related services and capabilities to internal and external customers including utilization management, behavioral health, integrated care delivery, palliative care, payment integrity services and subrogation services, as well as health and wellness programs. At the end of 2023, Carelon Services integrated Carelon Global Solutions into the Carelon family of offerings. The companies under Carelon Global Solutions have been providing services related to data management, information technology, and business operations since 2019 and were previously included within our Corporate & Other segment.

Our Corporate & Other segment includes our businesses that do not individually meet the quantitative threshold for an operating segment, as well as corporate expenses not allocated to our other reportable segments.

For additional information, see Note 20, “Segment Information,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Membership

Our medical membership includes the following customer types: Individual, Employer Group risk-based, Employer Group fee-based, BlueCard[®], Medicare, Medicaid and FEHB. In addition, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, the FEHB program, national employers and state-run programs servicing low-income, high-risk and underserved markets. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers’ unique needs. Further, CarelonRx was built to simplify pharmacy care and focus on the whole person, and we expect it will make it easier for our customers to achieve better health outcomes at a lower total cost of care while improving consumer experience.

We market our Individual, Medicare and certain Employer Group products with a smaller employee base through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships. Products for commercial customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer who work with industry specialists from our in-house sales force. In the Individual markets, we offer on-exchange products through state- or federally-facilitated marketplaces (the “Public Exchange”) in compliance with the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the “ACA”) and off-exchange products. Federal subsidies are available for certain members, subject to income and family size, who purchase Public Exchange products.

We made the decision to expand our participation in the Individual state- or federally-facilitated marketplaces for 2024. We also expect growth in our Public Exchange membership as Medicaid members who are no longer eligible for Medicaid coverage continue to exit the Medicaid program and seek coverage elsewhere. For 2024, we are offering Individual Public Exchange products in 141 of the 143 rating regions in which we operate, in comparison to 138 of the 143 rating regions in 2023. See “Regulation” below in this “Business” section for additional discussion about the Public Exchange marketplace.

Being a licensee of the BCBS association of companies, of which there were 34 independent primary licensees including us as of December 31, 2023, provides significant market value, especially when competing for very large multi-state employer groups. For example, each BCBS member company is able to utilize other BCBS licensees’ substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard[®]. BlueCard[®] host members are generally members who reside in or travel to a state in which an Elevance Health subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-

sponsored health plan serviced by a non-Elevance Health controlled BCBS licensee, which is the “home” plan. We perform certain administrative functions for BlueCard® host members, including claims pricing and administration, for which we receive service fees from the BlueCard® members’ home plan. Other administrative functions, including maintenance of enrollment information and customer services, are performed by the home plan. See “BCBSA Licenses” below in this “Business” section for additional information on our BCBSA licenses. We refer to members in our service areas licensed by the BCBSA as our BCBS-branded, or Anthem BCBS, business. Non-BCBS-branded business refers to members in our non-BCBS-branded, or Wellpoint plans, which include Amerigroup, Freedom Health, HealthSun, MMM, Optimum Healthcare and Simply Healthcare plans.

For additional information describing each of our customer types and changes in medical membership over the last three years, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations - *Membership*” included in Part II, Item 7 of this Annual Report on Form 10-K.

Product and Service Descriptions

Various forms of managed care products have been developed to contain the cost of healthcare by negotiating contracts with hospitals, physicians and other providers to deliver high-quality healthcare to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network physicians and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the healthcare system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and generally pay copayments, coinsurance and/or deductibles when they receive services.

Health Benefits

- *Commercial Risk-Based Products.* We offer employer groups a diversified mix of managed care risk-based products including: Preferred Provider Organization (“PPO”), Health Maintenance Organization (“HMO”), Consumer-Driven Health Plans (“CDHP”), Traditional Indemnity and Point-of-Service (“POS”) plans. PPO plans generally provide members the freedom to choose any healthcare provider, but require the member to pay a greater portion of the provider’s fee in the event the member chooses not to use a provider participating in the PPO’s network. HMOs include comprehensive managed care benefits generally through a participating network of physicians, hospitals and other providers. CDHPs generally combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee and allow some or all of the dollars remaining in the personal care account at year-end to be rolled over to the next year for future healthcare needs. Traditional indemnity plans offer the member an option to select any healthcare provider for covered services, with coverage subject to deductibles and coinsurance and with member cost-sharing usually limited by out-of-pocket maximums. POS products blend the characteristics of HMO, PPO and indemnity plans. In general, POS plans allow members to choose to seek care from a provider within the plan’s network or outside the network, subject to, among other things, certain deductibles and coinsurance.

We also offer Individual risk-based products on and off the Public Exchange, covering essential health benefits (as defined in the ACA) along with many other requirements and cost-sharing features.

- *Commercial Fee-Based Products.* We provide a broad array of managed care services to fee-based groups, including claims processing, provider network access, medical management, care management and wellness programs, actuarial services and other administrative services. Fee-based health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also charge a premium to underwrite stop loss insurance for employers that maintain fee-based plans but want to limit their retained risk.

In addition, we perform certain administrative functions for BlueCard® host members, discussed under “Membership” above, including claims pricing and administration, for which we receive service fees from the BlueCard® members’

home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

- *Specialty Products.* We offer an array of products and services to both risk-based and fee-based customers in conjunction with our health plans as well as to unaffiliated healthcare plans that are not Elevance Health subsidiaries.
 - *Stop Loss Insurance.* Our stop loss insurance arrangements are built around our clients' needs while assuming 100% of the risk. We offer specific and aggregate plans that will provide options to meet our clients' coverage terms, budget and risk tolerance; active claims management to help avoid errors and missing claims; as well as cost containment to assist our clients with claims and cost control.
 - *Dental.* Our dental plans include networks in certain states in which we operate and are offered on both a risk-based and fee-based basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans that offers in-network discounts across the country.
 - *Vision.* Our vision plans include networks within the states in which we operate and are offered on both a risk-based and fee-based basis.
 - *Life.* We offer an array of competitive individual and group term life insurance benefit products. The life insurance products include term life and accidental death and dismemberment.
 - *Disability.* We offer short-term and long-term disability and leave of absence products.
 - *Supplemental Health.* We offer supplemental health products, including accident, critical illness and hospital indemnity, which provide coverage for specific conditions or circumstances.

- *Medicare Plans.* We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare Advantage, including Special Needs Plans ("SNPs"), dual-eligible programs through Medicare-Medicaid Plans ("MMPs"), Medicare Supplement plans and Medicare Part D Prescription Drug Plans ("Medicare Part D").

Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage SNPs provide tailored benefits to special needs individuals who are institutionalized or have severe or disabling chronic conditions and to dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Advantage SNPs are coordinated care plans specifically designed to provide targeted care, covering all the healthcare services considered medically necessary for members and often providing professional care coordination services, with personal guidance and programs that help members maintain their health. Medicare Advantage membership also includes Medicare Advantage members in our Group Retiree Solutions business who are retired members of commercial accounts or groups who are not affiliated with our commercial accounts that have selected a Medicare Advantage product through us. MMP is focused on serving members who are dually eligible for Medicaid and Medicare. Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by the traditional Medicare Fee-For-Service program. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries.

- *Medicaid Plans and Other State-Sponsored Programs.* Our Medicaid business includes our managed care alternatives through public-funded healthcare programs, including Medicaid; Medicaid expansion programs; Temporary Assistance for Needy Families ("TANF"); programs for seniors and people with disabilities ("SPD"); Children's Health Insurance Programs ("CHIP"); and specialty programs such as those focused on long-term services and support ("LTSS"), HIV/AIDS, children living in foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities and/or developmental disabilities. The Medicaid program makes federal matching funds available to all states for the delivery of healthcare benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. Our Medicaid plans also cover certain dual-eligible customers, as previously described above, who also receive Medicare benefits. In 2023, we provided Medicaid and other state sponsored services, such as administrative services, in Arkansas, California, Colorado, District of Columbia, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia and Wisconsin.

- *Federal Employees Health Benefits Program.* FEHB members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management.
- *Medicare Administrative Operations.* Through our NGS subsidiary, we serve as a fiscal intermediary, carrier and Medicare administrative contractor for the federal government by providing administrative services for the Medicare program, Parts A and B, which generally provides coverage for persons who are 65 or older and for persons who are under 65 and disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other healthcare facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

CarelonRx

Our subsidiary CarelonRx markets and offers pharmacy services to our affiliated health plan customers throughout the country in our Health Benefits segment, as well as to customers outside of the health plans we own. Our comprehensive pharmacy services portfolio includes all core pharmacy services, such as home delivery and specialty pharmacies, claims adjudication, formulary management, pharmacy networks, rebate administration, a prescription drug database and member services.

CarelonRx delegates certain core pharmacy services to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation (“CVS”), pursuant to an agreement that is set to terminate on December 31, 2025 (the “CVS Agreement”).

Carelon Services

Business units in Carelon Services offer a broad array of healthcare related services and capabilities to internal and external customers, including utilization management, behavioral health, integrated care delivery, palliative care, payment integrity services and subrogation services, health and wellness programs, information technology services and global business process support. Key services offered include:

- *Advanced Analytics and Services.* We leverage data, analytics, and insights to help improve outcomes and lower the cost of care, by ensuring that our members receive safe, appropriate, high-quality, cost-effective care and that our providers are reimbursed accurately and timely.
- *Behavioral Health.* We provide comprehensive behavioral health management services through clinical and network administration. In a limited capacity, we also provide high-quality, evidence-based behavioral healthcare and counseling services through licensed clinicians in convenient and accessible locations.
- *Care Delivery.* We provide highly integrated, personalized care to patients with chronic and complex conditions, whether in their home, care centers, mobile units, skilled nursing facilities, hospitals, or virtually. Additionally, we provide non-hospice, community-based palliative care to deliver an extra layer of personalized support and whole-person care.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing, pricing, bid activity for government-sponsored programs, business consolidations, new strategic alliances, new competitors in the market, a proliferation of new products, technological advancements, the impact of legislative reform, increased quality awareness and price sensitivity among customers and changing market practices, such as increased usage of telehealth.

We believe that participants in the managed care industry compete for customers based on quality of service, price, access to provider networks, access to care management and wellness programs (including health information), innovation, effective use of digital technology, breadth and flexibility of products and benefits, expertise and reputation (including National Committee on Quality Assurance (“NCQA”) accreditation status as well as CMS Star ratings), brand recognition

and financial stability. Our ability to attract and retain customers is substantially tied to our ability to distinguish ourselves from our competitors in these areas.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with greater brand recognition over competitive product offerings. Typically, we are the largest participant in each of our BCBS branded markets, and thus are closely-watched by other health benefits companies.

Product pricing remains competitive and we strive to price our health benefit products and design our Medicare and Medicaid bids consistent with anticipated underlying medical trends. We believe our pricing and bid strategy, based on predictive modeling, proprietary research and data-driven processes, has positioned us to benefit from the potential growth opportunities available through entry into new markets, expansions in existing markets and as a result of any future changes to the current regulatory scheme. We believe that our pricing and bid strategy, brand name and network quality will provide a strong foundation for membership growth opportunities in the future.

Our provider networks give us a highly competitive unit cost position and provide distinctive service levels which allow us to offer a broad range of affordable health benefit products to our customers. To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider customer volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

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

In addition, the pharmacy industry is highly competitive, and CarelonRx is subject to competition from national, regional and local pharmacy service providers, insurers, health plans, large retail pharmacy chains, large retail stores, supermarkets, mail order pharmacies, web pharmacies and specialty pharmacies. Strong competition within the pharmacy industry has generated greater demand for lower product and service pricing, increased revenue sharing and enhanced product and service offerings.

Pricing and Underwriting of Our Products

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

Our revenue on Medicare policies is based on annual bids submitted to CMS. We base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period. In applying our pricing to each employer group and customer, we aim to maintain consistent, competitive and disciplined underwriting standards. We employ our proprietary accumulated actuarial and financial data to determine underwriting and pricing parameters for both our risk-based and fee-based businesses.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For our risk-based business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience or charged against future favorable experience. In addition, our ACA and government risk-based contracts may include minimum medical loss ratio, risk adjustment, or risk corridor arrangements, which also stabilize premiums based upon claims experience.

Our pharmacy services pricing through CarelonRx is presented to market via discounts off the average wholesale price for drugs dispensed through the retail, mail and specialty channels as well as through rebate projections. We utilize group-specific script data, formulary, network and clinical care program selection combined with administrative expense, risk and profit guidance to set market competitive pricing discounts and rebate projections. Pharmacy services pricing guidelines guide the underwriting process and undergo an annual external review process to ensure market competitiveness.

Networks and Provider Relations

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

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

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

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, we maintain capitation-based arrangements in certain markets where we determine that market dynamics result in it being a useful method to lower costs and reduce underwriting risk. Our provider engagement and contracting strategies have evolved to include value-based contracting arrangements that meet providers where they are in the movement from traditional fee-for-service to value-based care. These programs are designed to support commercial, Medicare and Medicaid programs and the unique characteristics of these populations. Our value-based contracting programs are designed to reward our contracted providers for improving the overall quality of care they deliver by adhering to evidence-based medicine. In addition, these value-based contracts also share with the providers total cost of care savings that are achieved by adhering to evidence-based medicine over time. For providers who contract in one of our value-based programs, we work with them to share gaps in care information and other important data to assist them in managing the care of their patients. Often providers will also grant us access to data to support the efficient administration of program components. This data can allow us to more efficiently capture information regarding the risk of our membership and the overall adherence to evidence-based medicine, as well as information to more efficiently perform utilization management administration.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our “per-case” reimbursement methods utilize many of the same attributes contained in Medicare’s Diagnosis Related Groups methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care

performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a pay-for-performance component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Seasonality

We experience seasonality in our Health Benefits segment. While our premium revenues are not seasonal, our benefit costs typically increase during the year as our risk-based members pay their contractual portion of claims responsibility under annual deductibles and reach their out-of-pocket maximum limits.

Medical Management Programs

We have a broad array of medical management activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and nurses with the goal of ensuring that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate setting. The medical management programs available to our members may vary depending on the particular plan or product in which they participate.

Care coordination is one of the strategies we utilize and is based on nationally recognized criteria developed by third-party medical specialists to help coordinate inpatient as well as outpatient care and monitor appropriate utilization of such services. Our case management focuses on identifying membership that will require a high level of intervention and providing assistance to manage their healthcare needs. Precertification is utilized to assess appropriateness of certain hospitalizations and other medical services prior to the services being rendered. Our medical policy committee determines our national policies and guidelines for the application of medical technologies, procedures and services and reviews these policies and guidelines at least once a year or as new published clinical evidence becomes available. We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We also work with outside experts through a process of external review to provide our members scientifically and clinically evidence-based medical care. Our web-based tools allow our members to obtain or compare cost estimates for care, including out-of-pocket costs.

We remain committed to assisting our members in making informed and value-based healthcare decisions, providing for easier navigation of healthcare services and delivering a better healthcare experience.

Care Management and Wellness Products and Programs

We continue to expand our suite of integrated care management programs and tools. Availability of these programs and tools to our members may depend on the particular plan or product in which they participate. Our care management tools and programs are designed to increase quality and reduce medical costs for our members and help them make better decisions about their well-being as they navigate the healthcare system. Our digital engagement platform, Sydney Health, is designed to give our members access to personalized health and wellness resources; medical, pharmacy, dental, vision, life and disability benefits details; as well as virtual care services, all in one place. Our care management, infertility services and maternity management programs serve as adjuncts to physician care. Through these programs, medical professionals help to educate participants regarding their care and condition. Our 24/7 NurseLine offers access to qualified, registered nurses to allow our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. Our CareMore subsidiary specializes in whole-person care for members with complex and chronic conditions to improve clinical outcomes and patient well-being. Our Aspire Health subsidiary engages with members near end of life and/or requiring palliative care to manage serious illnesses and improve quality of life during a difficult time. Beginning in 2024, Aspire Health and CareMore have rebranded and now operate under the new name, Carelon Health. With our integrated information systems and sophisticated data analytics, we help our members improve their compliance with evidence-based care guidelines, provide personal care notes that alert members to potential gaps in care, enable more prudent healthcare choices and assist in the realization of member out-of-pocket cost savings. Our employee assistance programs provide 24/7 telephonic support for personal and crisis events and provide resources such as counseling and referral assistance with childcare, health and wellness, financial issues, legal issues, adoption and daily living. We have a comprehensive behavioral health case management program supporting a wide range of members who are impacted by their behavioral health conditions, including specialty areas such as eating disorders, anxiety, depression and substance abuse. The program assists members and their

families with obtaining appropriate behavioral health treatment, offering community resources, providing education and telephonic support, and promoting provider collaboration.

Healthcare Quality Initiatives

Increasingly, the healthcare industry is able to define quality healthcare based on effective, safe, equitable and affordable care in preventive health, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to develop partnerships by working with our network physicians, hospitals, and social resources providers to improve the quality outcomes of the healthcare and social impact services provided to our members, their families, and the community-at-large. Our ability to promote quality medical care, address health-related social risks, and advance health equity has been recognized by NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality healthcare measures, including the Healthcare Effectiveness Data and Information Set (“HEDIS®”), have been incorporated into NCQA’s accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes, improving treatment for patients with heart disease, integration of behavioral health, and racial and ethnic stratification measurement to help close healthcare disparities.

Through our Carelon Medical Benefits Management, Inc. subsidiary, formerly known as AIM Specialty Health, we promote appropriate, safe and affordable member care in areas including imaging, sleep disorders, cardiac testing, oncology drugs and musculoskeletal procedures. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage provider communities and members in the more effective and efficient use of outpatient services and to promote the most appropriate use of clinical services to improve the quality of care.

Through our Carelon Post Acute Solutions, Inc. subsidiary, formerly known as myNEXUS, Inc., we perform management review for home health and post-acute institutional services provided to Medicare members, with the goal of ensuring they receive appropriate, high-quality care and supporting their transition back into the home. Effective management of these services can help reduce preventable hospital admissions and readmissions, thereby improving healthcare outcomes for patients. Additionally, Carelon Post Acute Solutions, Inc. has developed programs to address healthcare quality by identifying and closing care gaps. A social determinants of health program screens our members for social needs and connects members to appropriate community resources to encourage better care outcomes. Both medical benefits management and post acute solutions programs are examples of how we facilitate improvements in the quality of care provided to our members and promote cost-effective medical care.

The physical aspects of health have been traditionally the focus and the priority for healthcare. However, unique life circumstances and experiences impact every individual and their health. We seek to understand our members’ health-related social needs to create a healthcare system that synchronizes care delivery for physical, behavioral, social and pharmacy needs. We are advancing our efforts through consistent screening of our members for their social needs by using industry-standard tools such as the Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences, co-creating social action plans with our members, connecting members to related social support services, and evaluating the entire process for continuous quality improvement. We are committed to ensuring that all people, regardless of age, race or ethnicity, sexual orientation, gender identity, disability, and geographic or financial access can receive individualized care. Harnessing data gives a more complete picture of each individual and their health needs and can help make healthcare more personalized and equitable. Strengthening communities has a positive effect on health; therefore, we value and nurture our local ties, which are a key component of our whole-health approach and drive us to work closely with community organizations that create support networks. Using our data, we also identify the resources needed to support local residents, including the people who we serve, to ensure those resources can better meet local needs.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive, use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national association of independent Blue Cross and Blue Shield companies, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. Although

previously we did not have a right to sell products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products, under the terms of the subscriber settlement agreement and release (“Subscriber Settlement Agreement”) among the class of plaintiffs, BCBSA and Blue Cross and/or Blue Shield licensees, including us (the “Blue plans”) and some large national employers with self-funded plans (specifically identified in the Subscriber Settlement Agreement), have a right to request a second Blue plan bid in addition to a bid from the local Blue plan. The Subscriber Settlement Agreement received final approval in August 2022.

We are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various requirements and restrictions regarding our operations and our use of the BCBS names and marks. These requirements and restrictions include, among other things: minimum capital and liquidity requirements; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the BCBS system in contracts with third parties and in public statements; plan governance requirements; cybersecurity requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee’s annual combined local net revenue, as defined by the BCBSA, attributable to healthcare plans and related services within its service areas must be sold, marketed, administered or underwritten under the BCBS names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; governance requirements such as a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. In addition, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency or the appointment of a trustee or receiver or the commencement of any action against us seeking our dissolution could cause a termination of our license agreements.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A, “Risk Factors” in this Annual Report on Form 10-K for additional details on the impact if we were not to comply with these license agreements and Note 14, “Commitments and Contingencies – *Litigation and Regulatory Proceedings – Blue Cross Blue Shield Antitrust Litigation*,” of the Notes to our Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the Subscriber Settlement Agreement.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. These laws and regulations, which can vary significantly from jurisdiction to jurisdiction, restrict how we conduct our businesses and result in additional burdens and costs to us. Further, federal and state laws and regulations are subject to amendments and changing interpretations in each jurisdiction. The application of these complex legal and regulatory requirements to the detailed operation of our businesses creates areas of uncertainty. In addition, there are numerous proposed healthcare laws and regulations at the federal and state levels, including single payer, Medicare for All and public option proposals, some of which could materially adversely affect our businesses if they were to be enacted.

Supervisory agencies, including federal and state regulators, departments of health and insurance and secretaries of state, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate our products and services in great detail;
- regulate, limit, or suspend our ability to market products, including participation in Medicare and the Public Exchanges;
- determine through a procurement process our ability to participate in certain programs, including state Medicaid programs;

- retroactively adjust premium rates;
- monitor our solvency and reserve adequacy;
- audit, and recover audit discrepancies, including risk adjustment data validation (“RADV”) audits;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

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

The health benefits business, pharmacy services, and related healthcare products and services businesses also may be adversely impacted by court and regulatory decisions that expand or invalidate the interpretations of existing statutes and regulations. It is uncertain whether we could recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

The Consolidation Appropriations Act of 2023

Under the Consolidated Appropriations Act of 2023, Congress decoupled Medicaid eligibility redetermination from the Public Health Emergency initially declared in January 2020 relating to COVID-19 (the “PHE”). As a result, states were permitted to begin removing ineligible beneficiaries from their Medicaid programs starting April 1, 2023, and the majority of our Medicaid markets began doing so as of June 30, 2023. This process is anticipated to take up to 14 months to complete, although most states are expected to complete the redetermination process by June 30, 2024. As redeterminations have resumed, we have experienced a decline in our Medicaid membership. We have seen, and we expect to continue to see, growth in our commercial plans, including through the Public Exchanges, and Medicare as members who are no longer eligible for Medicaid coverage in our 14 commercial states seek coverage elsewhere. On May 11, 2023, the PHE ended in accordance with the Biden Administration’s January 30, 2023 announcement.

The Inflation Reduction Act of 2022

The Inflation Reduction Act of 2022 (the “Inflation Reduction Act”), which was signed into law in August 2022, contains a variety of provisions that impact our business, including an extension of the American Rescue Plan Act of 2021’s enhanced Premium Tax Credits (“PTC”) through 2025; imposing a new corporate alternative minimum tax; providing a one percent excise tax on repurchases of stock made after December 31, 2022; allowing CMS to negotiate prices on a limited set of prescription drugs in Medicare Parts B and D beginning in 2026; instituting caps on insulin cost sharing in Medicare Parts B and D; redesigning of the Medicare Part D benefit; adding a requirement that drug manufacturers pay rebates if prices increase beyond inflation; and delaying the implementation of the Trump Administration Medicare drug rebate rule to 2032. The extension of the enhanced PTC has allowed for growth in Individual Public Exchange enrollment as Medicaid eligibility redeterminations have resumed, supporting continuity of coverage for more people.

The Consolidated Appropriations Act of 2021

The Consolidated Appropriations Act of 2021 (the “2021 Appropriations Act”) has impacted us since its passage and in the future may have a material effect upon our business, including procedures and coverage requirements related to surprise medical bills and new mandates for continuity of care for certain patients, price comparison tools, disclosure of broker compensation, mental health parity reporting, and reporting on pharmacy benefits and drug costs. The requirements of the 2021 Appropriations Act applicable to us have varying effective dates, some of which were effective in December 2021 and during 2022, and others that were extended into 2023 since the enactment of the 2021 Appropriations Act.

State Regulation of Insurance Companies and HMOs

Our insurance and HMO subsidiaries must obtain a certificate of authority and maintain that license in the jurisdictions in which they conduct business. The National Association of Insurance Commissioners (“NAIC”) has adopted model regulations that, where adopted by states, require expanded governance practices, risk and solvency assessment reporting and the filing of periodic financial and operating reports. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. Health insurers and HMOs are subject to state examination and periodic license renewal.

In addition, we are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements, as well as restrictions on transactions between an insurer or HMO and its affiliates, and may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies. These holding company laws and regulations generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance and general business operations. State insurance holding company laws and regulations require notice or prior regulatory approval of transactions including acquisitions, material intercompany transfers of assets, guarantees and other transactions between the regulated companies and their affiliates, including parent holding companies. Applicable state insurance holding company acts also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. “Control” is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Dispositions of control generally are also regulated under the state insurance holding company acts.

The states of domicile of our regulated subsidiaries have statutory risk-based capital (“RBC”) requirements for health and other insurance companies and HMOs based on the Risk-Based Capital (RBC) For Health Organizations Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company’s investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. The law requires increasing degrees of regulatory oversight and intervention as a company’s RBC declines. As of December 31, 2023, the RBC levels of our insurance and HMO subsidiaries exceeded all applicable mandatory RBC requirements. For more information on RBC capital and additional liquidity and capital requirements for a licensee of the BCBSA, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and Capital Resources – *Capital Resources*,” included in Part II, Item 7 of this Annual Report on Form 10-K.

Ongoing Requirements and Changes Stemming from the ACA

Since its enactment in 2010, the ACA has introduced new risks, regulatory challenges and uncertainties, has impacted our business model and strategy and has required changes in the way our products are designed, underwritten, priced, distributed and administered. We expect the ACA will continue to significantly impact our business and results of operations, including pricing, minimum medical loss ratios (“MLRs”) and the geographies in which our products are available. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, including evolving methodology for ratings and quality bonus payments. CMS also frequently proposes changes to its program that audits data submitted under the risk adjustment programs in ways that could increase financial recoveries from plans. We will continue to evaluate the impact of the ACA as any further developments occur.

Certain significant provisions of the ACA include, among others:

- The creation of Public Exchanges for individuals and small group customers.
- The establishment of minimum MLR thresholds by line of business for the commercial market (which may be subject to more restrictive MLR thresholds under state regulations, such as those in New York). Medicare Advantage or Medicare Part D prescription drug plans that do not meet the mandated threshold will have to pay a minimum MLR rebate, will be subject to restricted enrollment if MLR is below the threshold for three consecutive years and are subject to contract termination if the plan’s MLR is below the threshold for five consecutive years. In addition, state Medicaid programs are required to set managed care capitation rates such that a minimum MLR is projected to be achieved; however, states are not required to collect remittances if the minimum MLR is not achieved.

Approximately 52.3% and 18.0% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2023. Approximately 52.3% and 17.5% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2022.

- The creation of an incentive payment program for Medicare Advantage plans. CMS developed the Medicare Advantage Star ratings system, which awards between 1.0 and 5.0 Stars to Medicare Advantage plans based on

performance in several categories, including quality of care and customer service. The Star ratings are used by CMS to award quality-based bonus payments to plans that receive a rating of 4.0 or higher. The methodology and measures included in the Star ratings system can be modified by CMS annually. CMS released our 2024 Star ratings in October 2023, which will be used to determine our Medicare Advantage plans' Star quality bonus payments beginning in 2025. Based on our membership at September 1, 2023, 34% of our Medicare Advantage members were in plans with 2024 Star ratings of at least 4.0 Stars, compared to 64% of our Medicare Advantage members being in plans with 2023 Star ratings of at least 4.0 Stars based on our membership at September 1, 2022. This change in our 2024 Star ratings is expected to impact our Star quality bonus payments and plan level rebates beginning in 2025. We expect a reduction to our 2025 operating revenue of approximately \$500 million, net of offsets from contracting provisions. Further, we expect to partially mitigate the financial impact to our 2025 operating gain and net income through various strategies such as contract diversification, operating expense efficiencies, capital deployment alternatives and network enhancements.

- The implementation of a Medicare Advantage payment formula, which prevents reimbursement rates from increasing as much as otherwise would be expected.

We continue to evaluate our experience in the Public Exchange markets. Based on the viability of the Public Exchanges and availability of federal subsidies, we have made a decision to expand our participation in the Individual state, or federally-facilitated, marketplaces for 2024. We also expect continued growth in our Public Exchange membership as Medicaid members who are no longer eligible for Medicaid coverage continue to exit the Medicaid program and seek coverage elsewhere. For 2024, we are offering Individual Public Exchange products in 141 of the 143 rating regions in which we operate, in comparison to 138 of the 143 rating regions in 2023. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows, and may require further adjustments to our rates and participation going forward. Changes to our business environment are likely to continue as elected officials at the federal and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees.

Pharmacy Services and Drug Benefit Regulation

Pharmacy services, including PBMs, are regulated at both the federal and state levels and must comply with federal and state statutes and regulations governing a PBM's business, including, but not limited to pharmacy network restrictions and configurations, formulary management, affiliate pharmacy reimbursement, anti-steering to affiliated pharmacies, pharmacy effective rates, guarantees and reconciliations, reimbursement pricing type mandates, purchase discount and/or rebate arrangements with drug manufacturers, advertising and licensing. For example, in recent years the state and federal governments have banned certain PBM business practices, including "gag clauses," which prohibit pharmacists from informing patients when a lower cost drug was available as a substitute, and "clawbacks," which occurred when PBMs sought to recoup the difference between the reimbursed cost of the drug and the patient's copay when the drug itself was less expensive than the copay paid by the patient. Regulation in the states varies dramatically and ranges from licensure of PBMs as third-party administrators, licensure specifically as a PBM, and licensure accompanied by additional disclosures and limitations of business practices to varying degrees.

PBMs are also subject to continued changes in public policy, legislation, laws, and regulations relating to drug benefits and pharmacy services, which include, but are not limited to (1) regulation of rebates from drug manufacturers that would require rebate dollars to be applied at the point-of-sale, (2) federal policy changes to set the prices for a subset of drugs covered under the Medicare program, (3) reforms to the Medicare drug benefit, such as beneficiary cost-sharing changes that aim to lower consumer costs, (4) attempts at both the federal and state levels to prohibit the use of spread pricing contracts in both the commercial and Medicaid markets, (5) prior authorizations of drugs, (6) transparency and public disclosure of costs and profits, (7) prohibiting exclusive specialty and mail pharmacy networks, (8) limiting accreditation and credentialing requirements, and (9) consumer choice/any willing provider requirements. These changes in public policy, legislation, laws, and regulations have the potential to have broad impacts on our pharmacy benefit management services and could materially adversely affect our business.

Our pharmacy services business include home delivery and specialty pharmacies, as well as clinic-based pharmacies, which must be licensed as pharmacies in the states in which they are located. Certain pharmacies must also register with the U.S. Drug Enforcement Agency ("DEA") and individual state-controlled substance authorities to dispense controlled

substances. In addition to adhering to the laws and regulations in the states where our pharmacies are located, we may also be required to comply with certain laws and regulations in certain states into which one of our pharmacies delivers prescription drugs, including those requiring us to register with Boards of Pharmacy as a non-resident pharmacy. These non-resident states generally expect our pharmacies to follow the laws of the state in which the pharmacies are located, but some non-resident states also require us to comply with certain of their pharmacy regulations as well. Additionally, pharmacies that participate in Medicare or Medicaid pharmacy networks are required to comply with applicable Medicare and Medicaid provider rules and regulations.

Privacy, Confidentiality and Data Standards Regulation

The federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the administrative simplification provisions of HIPAA impose a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses) and their business associates relating to the use, disclosure and safeguarding of protected health information. These requirements include uniform standards of common electronic healthcare transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers.

Also, the Health Information Technology for Economic and Clinical Health (“HITECH”) Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations have imposed additional requirements on the use and disclosure of protected health information such as additional data breach notification and reporting requirements, contracting requirements for HIPAA business associate agreements, strengthened enforcement mechanisms and increased penalties for HIPAA violations. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to “opt out” of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directed HHS to develop a set of voluntary cybersecurity best practices for organizations in the healthcare industry, which were issued in 2018.

New cybersecurity disclosure rules adopted by the Securities and Exchange Commission (SEC) became effective in December 2023. Public companies that experience a cybersecurity incident that is determined by the company to be material are now required to file a Current Report on Form 8-K describing the material aspects of the nature, scope and timing of the incident, and the material impact or reasonably likely material impact on the company, including its financial condition and results of operations, within four business days after the company determines that the incident is material.

In addition, Public Exchanges are required to adhere to privacy and security standards with respect to personally identifiable information and to impose privacy and security standards that are at least as protective as those the Public Exchange has implemented for itself on insurers offering plans through the Public Exchanges and their designated downstream entities, including pharmacy services providers and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Furthermore, states have begun enacting more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency that may affect our privacy and security practices, such as state laws like the California Privacy Rights Act of 2020 that govern the use, disclosure and protection of member data and impose additional breach notification requirements. The NAIC is drafting a new privacy model act, which could expand consumer privacy rights. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Complying with conflicting cybersecurity regulations and varying enforcement philosophies, which may differ from state to state, requires significant resources and may materially and adversely affect our ability to standardize our products and services across state lines.

Federal regulations have been finalized in the following areas that will continue to materially impact our operations:

- Federal regulations on data interoperability that require claims data to be made available to third parties unaffiliated with us that may not be HIPAA regulated; and
- Federal regulations requiring hospitals and health insurers to publish negotiated prices for services, including the health plan price transparency regulations issued in October 2020 by the U.S. Departments of Health and Human Services, Labor and Treasury (the “Health Plan Transparency Rule”).

Beginning in July 2022, the Health Plan Transparency Rule required us to disclose, on a monthly basis, detailed pricing information regarding negotiated rates for all covered items and services between the plan or issuer and in-network providers and historical payments to, and billed charges from, out-of-network providers. Additionally, beginning in 2023, we were required to make available to members personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered healthcare items and services, including prescription drugs. Effective January 1, 2024, this requirement has expanded to include all items and services.

Employee Retirement Income Security Act of 1974

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

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies and HMOs can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company or HMO becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments are made retrospectively. Some states permit insurers or HMOs to recover assessments paid through full or partial premium tax offsets or through future policyholder surcharges. The amount and timing of any future assessments cannot be predicted with certainty; however, future assessments are likely to occur.

International Regulation

We have various international subsidiaries, which provide administrative and other services, that are subject to different, and sometimes more stringent, legal and regulatory requirements that vary widely by jurisdiction. In addition, our non-U.S. operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, including but not limited to, the Foreign Corrupt Practices Act and corresponding foreign laws governing anti-bribery, anti-corruption, anti-money laundering, data protection and privacy, employment, and other regulatory oversight initiatives.

Human Capital

The foundation of our strategy starts with our culture, and our associates are critical to fulfilling our purpose of improving the health of humanity. As of December 31, 2023, our employee population, including all full-time, part-time and temporary workers, consisted of approximately 104,900 individuals, 78,100 in the United States and 26,800 internationally. We believe we have built a high-performance culture that enhances our ability to deliver on our commitments and guides us to address the challenges of today. We believe that our culture allows us to attract and retain talented and experienced individuals to support the communities we serve.

Each year we conduct an internal associate engagement survey that provides our associates with an opportunity to share their opinions and experiences with respect to their roles, their teams and the Company, and we also offer online feedback tools. Our management team reviews, monitors and analyzes associate feedback and acts on responses to identify

opportunities to adjust our policies and benefits to improve our associates' experiences. More than 90% of our associates participated in the survey conducted in 2023.

Because dedication to human capital management is a core component of our corporate governance, the Compensation and Talent Committee of our Board of Directors regularly reviews and discusses management's approach to talent acquisition and retention, and also monitors our programs and practices related to workforce diversity and inclusion.

Inclusion & Diversity

The diversity of our associates is central to achieving key strategies and improving performance. We strive to attract, develop, maintain and support a diverse and inclusive workforce comprised of a vast array of backgrounds, life experiences and cultures, which we believe enables a deeper connection with our members, allowing us to better serve our members and communities, and drives greater business results. In order to build diverse and inclusive teams, our CEO and executive management set expectations for inclusive leadership and hold leaders accountable for achieving results.

As of December 31, 2023, our U.S. associate population was approximately 77% female and 50% racially and ethnically diverse, while 65% of our managers in the U.S. were female and 38% were racially or ethnically diverse.

Fair Pay

We are committed to a fair pay workplace. We were in the first cohort of companies certified by the Fair Pay Workplace ("FPW"), an independent certification that takes a holistic approach to pay equity, partnering to design an annual pay equity action plan that includes a perpetual review of all positions, new hires and promotions to effect meaningful and measurable change. This independent certification is based on a set of publicly available rules and standards and the endorsed methodology of a group of leading experts from forward-thinking corporations, academia, human resources, data science and the legal field. After partnering with and overseeing our review process, FPW has validated our analysis of our associate population, which found that pay for females in the U.S. is within 1% of their male counterparts and pay for people of color in the U.S. is equal to their white counterparts, after taking into account neutral job-related factors.

Talent Development

Growing and developing our talent internally is key to our succession plans and our ability to lead at our best every day. To inspire a high-performance culture and promote talent excellence, we offer individual, career and leadership development opportunities, encouraging associates to continually learn and grow. We offer various instructor-led and virtual instructor-led programs and maintain a vast curriculum of relevant, on-demand learning and development resources. In 2023, we invested a significant amount in human capital development, averaging approximately 28 hours of training and development per associate. Over 19% of our U.S. workforce participated in our nine business resource groups, which provide associates meaningful opportunities to connect, collaborate and grow.

Health & Wellbeing

We have the privilege of touching the lives of millions of people each day, starting with the health of our own associates. To improve the health and wellbeing of our associates, we offer a comprehensive compensation package, including competitive salaries, a 401(k) plan and medical, dental, vision and disability coverage. In addition, we offer our associates wellness and behavioral health programs and tools to help them get and stay healthy and more easily manage their work and personal lives. In 2023, we formalized our workforce practices and instituted a mixed hybrid, remote and in-office workplace strategy. We also foster associate engagement through a variety of activities based in our key office locations.