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

(Mark One)

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

For the Quarterly Period Ended September 30, 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	**35-2145715**
(State or other jurisdiction of incorporation or organization)	**(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

Not Applicable
(Former name, former address and former fiscal year, if changed since last report)

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, $0.01 par value	ELV	New York Stock Exchange

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	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐		

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 is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of October 11, 2023, 234,959,135 shares of the Registrant's Common Stock were outstanding.

Elevance Health, Inc.

Quarterly Report on Form 10-Q
For the Period Ended September 30, 2023

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PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS

Elevance Health, Inc.
Consolidated Balance Sheets

(In millions, except share and per share data)	September 30, 2023 (Unaudited)	December 31, 2022 (Restated)
Assets		
Current assets:		
Cash and cash equivalents	$ 10,919	$ 7,387
Fixed maturity securities (amortized cost of $30,139 and $28,226; allowance for credit losses of $3 and $9)	27,811	25,952
Equity securities	165	953
Premium receivables	7,883	7,083
Self-funded receivables	3,756	4,663
Other receivables	5,293	4,298
Other current assets	5,358	5,281
Total current assets	61,185	55,617
Long-term investments:		
Fixed maturity securities (amortized cost of $874 and $789; allowance for credit losses of $0 and $0)	816	752
Other invested assets	6,118	5,685
Property and equipment, net	4,248	4,316
Goodwill	25,291	24,383
Other intangible assets	10,491	10,315
Other noncurrent assets	2,329	1,687
Total assets	$ 110,478	$ 102,755
Liabilities and equity		
Liabilities		
Current liabilities:		
Medical claims payable	$ 16,176	$ 15,596
Other policyholder liabilities	5,681	5,933
Unearned income	4,332	1,112
Accounts payable and accrued expenses	5,983	5,607
Short-term borrowings	—	265
Current portion of long-term debt	799	1,500
Other current liabilities	10,366	9,683
Total current liabilities	43,337	39,696
Long-term debt, less current portion	24,045	22,349
Reserves for future policy benefits	807	803
Deferred tax liabilities, net	1,779	2,015
Other noncurrent liabilities	1,971	1,562
Total liabilities	71,939	66,425
Commitments and contingencies – Note 11		
Shareholders' equity		
Preferred stock, without par value, shares authorized – 100,000,000; shares issued and outstanding – none	—	—
Common stock, par value $0.01, shares authorized – 900,000,000; shares issued and outstanding – 234,906,987 and 237,958,067	2	2
Additional paid-in capital	8,830	9,084
Retained earnings	32,103	29,647
Accumulated other comprehensive loss	(2,512)	(2,490)
Total shareholders' equity	38,423	36,243
Noncontrolling interests	116	87
Total equity	38,539	36,330
Total liabilities and equity	$ 110,478	$ 102,755

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Income
(Unaudited)

	Three Months Ended September 30		Nine Months Ended September 30	
	2023	**2022**	**2023**	**2022**
(In millions, except per share data)		(Restated)		(Restated)
Revenues				
Premiums	$ 35,259	$ 33,722	$ 107,716	$ 99,583
Product revenue	5,177	3,972	14,058	10,841
Service fees	2,044	1,931	5,981	5,569
Total operating revenue	42,480	39,625	127,755	115,993
Net investment income	493	371	1,296	1,112
Net losses on financial instruments	(124)	(57)	(358)	(439)
Total revenues	42,849	39,939	128,693	116,666
Expenses				
Benefit expense	30,606	29,421	92,996	86,447
Cost of products sold	4,648	3,437	12,456	9,389
Operating expense	5,470	4,516	15,088	13,133
Interest expense	259	213	771	622
Amortization of other intangible assets	212	225	668	520
Total expenses	41,195	37,812	121,979	110,111
Income before income tax expense	1,654	2,127	6,714	6,555
Income tax expense	354	529	1,554	1,544
Net income	1,300	1,598	5,160	5,011
Net (income) loss attributable to noncontrolling interests	(11)	5	(29)	18
Shareholders' net income	$ 1,289	$ 1,603	$ 5,131	$ 5,029
Shareholders' net income per share				
Basic	$ 5.48	$ 6.69	$ 21.70	$ 20.91
Diluted	$ 5.45	$ 6.62	$ 21.56	$ 20.67
Dividends per share	$ 1.48	$ 1.28	$ 4.44	$ 3.84

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Comprehensive Income
(Unaudited)

(In millions)	Three Months Ended September 30		Nine Months Ended September 30	
	2023	**2022**	**2023**	**2022**
		(Restated)		(Restated)
Net income	$ 1,300	$ 1,598	$ 5,160	$ 5,011
Other comprehensive (loss) income, net of tax:				
Change in net unrealized losses/gains on investments	(352)	(639)	(44)	(2,630)
Change in non-credit component of impairment losses on investments	2	(1)	(1)	(3)
Change in net unrealized gains/losses on cash flow hedges	1	2	16	8
Change in net periodic pension and postretirement costs	2	7	7	23
Change in future policy benefits	3	7	2	24
Foreign currency translation adjustments	(4)	(7)	(2)	(15)
Other comprehensive loss	(348)	(631)	(22)	(2,593)
Net (income) loss attributable to noncontrolling interests	(11)	5	(29)	18
Other comprehensive loss attributable to noncontrolling interests	2	3	—	11
Total shareholders' comprehensive income	$ 943	$ 975	$ 5,109	$ 2,447

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Cash Flows
(Unaudited)

	Nine Months Ended September 30	
	2023	**2022**
(In millions)		(Restated)
Operating activities		
Net income	$ 5,160	$ 5,011
Adjustments to reconcile net income to net cash provided by operating activities:		
Net losses on financial instruments	358	439
Equity in net earnings of other invested assets	70	(304)
Depreciation and amortization	1,321	1,202
Impairment of property and equipment	446	—
Deferred income taxes	(361)	(183)
Share-based compensation	217	191
Changes in operating assets and liabilities:		
Receivables, net	(727)	(678)
Other invested assets	(46)	46
Other assets	(936)	(465)
Policy liabilities	333	1,588
Unearned income	3,220	2,548
Accounts payable and other liabilities	1,717	598
Income taxes	257	(41)
Other, net	3	(35)
Net cash provided by operating activities	11,032	9,917
Investing activities		
Purchases of investments	(24,337)	(19,612)
Proceeds from sale of investments	7,830	9,402
Maturities, calls and redemptions from investments	14,531	7,606
Changes in securities lending collateral	55	(677)
Purchases of subsidiaries, net of cash acquired	(1,570)	(623)
Purchases of property and equipment	(970)	(854)
Other, net	(82)	(91)
Net cash used in investing activities	(4,543)	(4,849)
Financing activities		
Net proceeds from commercial paper borrowings	—	375
Proceeds from long-term borrowings	2,574	1,286
Repayments of long-term borrowings	(1,908)	(982)
Proceeds from short-term borrowings	—	1,365
Repayments of short-term borrowings	(265)	(1,375)
Changes in securities lending payable	(54)	685
Changes in bank overdrafts	(523)	181
Repurchase and retirement of common stock	(1,748)	(1,748)
Cash dividends	(1,049)	(924)
Proceeds from issuance of common stock under employee stock plans	112	152
Taxes paid through withholding of common stock under employee stock plans	(99)	(91)
Other, net	5	16
Net cash used in financing activities	(2,955)	(1,060)
Effect of foreign exchange rates on cash and cash equivalents	(2)	(16)
Change in cash and cash equivalents	3,532	3,992
Cash and cash equivalents at beginning of period	7,387	4,880
Cash and cash equivalents at end of period	$ 10,919	$ 8,872

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Changes in Equity
(Unaudited)

(In millions)	Total Shareholders' Equity						
	Common Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Noncontrolling Interests	Total Equity
	Number of Shares	Par Value					
December 31, 2022 (restated)	238.0	$ 2	$ 9,084	$ 29,647	$ (2,490)	$ 87	$ 36,330
Net income	—	—	—	1,989	—	15	2,004
Other comprehensive income	—	—	—	—	440	2	442
Repurchase and retirement of common stock, including excise tax	(1.3)	—	(51)	(575)	—	—	(626)
Dividends and dividend equivalents	—	—	—	(354)	—	—	(354)
Issuance of common stock under employee stock plans, net of related tax benefits	0.4	—	6	—	—	—	6
Convertible debenture repurchases, conversions and tax adjustments	—	—	(342)	—	—	—	(342)
March 31, 2023	237.1	2	8,697	30,707	(2,050)	104	37,460
Net income	—	—	—	1,853	—	3	1,856
Other comprehensive loss	—	—	—	—	(116)	—	(116)
Repurchase and retirement of common stock, including excise tax	(1.4)	—	(52)	(600)	—	—	(652)
Dividends and dividend equivalents	—	—	—	(352)	—	—	(352)
Issuance of common stock under employee stock plans, net of related tax benefits	0.2	—	116	—	—	—	116
June 30, 2023	235.9	2	8,761	31,608	(2,166)	107	38,312
Net income	—	—	—	1,289	—	11	1,300
Other comprehensive loss	—	—	—	—	(346)	(2)	(348)
Repurchase and retirement of common stock, including excise tax	(1.1)	—	(40)	(445)	—	—	(485)
Dividends and dividend equivalents	—	—	—	(349)	—	—	(349)
Issuance of common stock under employee stock plans, net of related tax benefits	0.1	—	109	—	—	—	109
September 30, 2023	234.9	$ 2	$ 8,830	$ 32,103	$ (2,512)	$ 116	$ 38,539

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Changes in Equity (continued)
(Unaudited)

(In millions)	Total Shareholders' Equity						
	Common Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Noncontrolling Interests	Total Equity
	Number of Shares	Par Value					
December 31, 2021 (restated)	241.8	$ 2	$ 9,148	$ 27,142	$ (197)	$ 68	$ 36,163
Adoption of Accounting Standards Update 2020-06	—	—	—	(23)	—	—	(23)
January 1, 2022 (restated)	241.8	2	9,148	27,119	(197)	68	36,140
Net income (loss) (restated)	—	—	—	1,789	—	(10)	1,779
Other comprehensive loss (restated)	—	—	—	—	(1,049)	(5)	(1,054)
Noncontrolling interests adjustment	—	—	—	—	—	3	3
Repurchase and retirement of common stock	(1.2)	—	(45)	(500)	—	—	(545)
Dividends and dividend equivalents	—	—	—	(312)	—	—	(312)
Issuance of common stock under employee stock plans, net of related tax benefits	0.5	—	39	—	—	—	39
Convertible debenture repurchases and conversions	—	—	9	—	—	—	9
March 31, 2022 (restated)	241.1	2	9,151	28,096	(1,246)	56	36,059
Net income (loss) restated	—	—	—	1,637	—	(3)	1,634
Other comprehensive loss (restated)	—	—	—	—	(905)	(3)	(908)
Noncontrolling interests adjustment	—	—	—	—	—	5	5
Repurchase and retirement of common stock	(1.3)	—	(48)	(576)	—	—	(624)
Dividends and dividend equivalents	—	—	—	(310)	—	—	(310)
Issuance of common stock under employee stock plans, net of related tax benefits	0.2	—	111	—	—	—	111
Convertible debenture repurchases and conversions	—	—	(80)	—	—	—	(80)
June 30, 2022 (restated)	240.0	2	9,134	28,847	(2,151)	55	35,887
Net income (loss) restated	—	—	—	1,603	—	(5)	1,598
Other comprehensive loss	—	—	—	—	(628)	(3)	(631)
Noncontrolling interests adjustment	—	—	—	—	—	5	5
Repurchase and retirement of common stock	(1.2)	—	(47)	(532)	—	—	(579)
Dividends and dividend equivalents	—	—	—	(307)	—	—	(307)
Issuance of common stock under employee stock plans, net of related tax benefits	0.2	—	103	—	—	—	103
Convertible debenture repurchases and conversions	—	—	(21)	—	—	—	(21)
September 30, 2022 (restated)	239.0	$ 2	$ 9,169	$ 29,611	$ (2,779)	$ 52	$ 36,055

See accompanying notes.

Elevance Health, Inc.
Notes to Consolidated Financial Statements
(Unaudited)
September 30, 2023

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

1. Organization

References to the terms "we," "our," "us" or "Elevance Health" used throughout these Notes to Consolidated Financial Statements refer to Elevance Health, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia and Puerto Rico unless the context otherwise requires.

Elevance Health is a health company with the purpose of improving the health of humanity. We are one of the largest health insurers in the United States in terms of medical membership, serving over 47 million medical members through our affiliated health plans as of September 30, 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 unaffiliated health plans, including pharmacy services and 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, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also serve members in numerous states as Amerigroup, Freedom Health, HealthLink, HealthSun, MMM, Optimum HealthCare, Simply Healthcare, UniCare and/or Wellpoint. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. 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 as CarelonRx and other healthcare-related services as Carelon Services, Aspire Health, Carelon Behavioral Health and CareMore.

As we announced in 2022, over the next several years 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; and
- 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 brands 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 our 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). In 2022, we managed and presented our operations through the following four reportable segments: Commercial & Specialty Business, Government Business, CarelonRx and Other. Previously reported information in this Quarterly Report on Form 10-Q has been reclassified to conform to the new presentation. For additional discussion regarding our segments, including the changes made, see Note 15 "Segment Information."

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying unaudited consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP") for interim financial reporting. Accordingly, they do not include all of the information and footnotes required by GAAP for annual financial statements. We have omitted certain footnote disclosures that would substantially duplicate the disclosures in our Annual Report on Form 10-K for the year ended December 31, 2022 (the "2022 Annual Report on Form 10-K"), unless the information contained in those disclosures materially changed or is required by GAAP. We have filed Exhibit 99.1 to this Quarterly Report on 10-Q to recast certain prior years' financial information and related disclosures to reflect the changes to our reportable segments beginning in the first quarter of 2023 discussed above, as well as the impact of the adoption of a new accounting standard related to the accounting for long-duration insurance contracts, which we adopted on January 1, 2023, using a modified retrospective transition method as of January 1, 2021. The recast financial information and related disclosures set forth in Exhibit 99.1 to this Quarterly Report on Form 10-Q present such financial information and related disclosures in these items as they would have appeared had we changed our reportable segments and adopted the new accounting standard prior to January 1, 2023 and do not reflect events or developments that may have occurred subsequent to the filing of our 2022 Annual Report on Form 10-K.

In the opinion of management, all adjustments, including normal recurring adjustments, necessary for a fair statement of the consolidated financial statements as of and for the three and nine months ended September 30, 2023 and 2022 have been recorded. The results of operations for the three and nine months ended September 30, 2023 are not necessarily indicative of the results that may be expected for the full year ending December 31, 2023, or any other period. The seasonal nature of portions of our health care and related benefits business, as well as competitive and other market conditions, may cause full-year results to differ from estimates based upon our interim results of operations. These unaudited consolidated financial statements should be read in conjunction with our audited consolidated financial statements as of and for the year ended December 31, 2022 included in Exhibit 99.1 to this Quarterly Report on Form 10-Q.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar ("USD"). We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in "Foreign currency translation adjustments" in our consolidated statements of comprehensive income.

Cash and Cash Equivalents: We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits, and we have cash and cash equivalents on deposit to meet certain regulatory requirements. These amounts totaled $300 and $258 at September 30, 2023 and December 31, 2022, respectively, and are included in the cash and cash equivalents line on our consolidated balance sheets.

Investments: We classify fixed maturity securities in our investment portfolio as "available-for-sale" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, we write down the fixed maturity security's cost basis to fair value and record an impairment loss in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or if it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, we recognize the credit component of the impairment as an allowance for credit loss in our consolidated balance sheets and record an impairment loss in our consolidated statements of income. The non-credit component of the impairment is recognized in accumulated other comprehensive loss. Furthermore, unrealized losses entirely caused by non-credit-related factors related to fixed

maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive loss.

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

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the purchase date of the securities. Such adjustments are reported within net investment income.

The changes in fair value of our marketable equity securities are recognized in our results of operations within net gains and losses on financial instruments. Certain marketable equity securities are held to satisfy contractual obligations and are reported under the caption “Other invested assets” in our consolidated balance sheets.

We have corporate-owned life insurance policies on certain participants in our deferred compensation plans and other members of management. The cash surrender value of the corporate-owned life insurance policies is reported under the caption “Other invested assets” in our consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest may enable us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported within net investment income. The equity method investments are reported under the caption “Other invested assets” in our consolidated balance sheets.

Investment income is recorded when earned. All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. We recognize the collateral as an asset, which is reported under the caption “Other current assets” on our consolidated balance sheets, and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported under the caption “Other current liabilities.” The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive loss as a separate component of shareholders’ equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities’ value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondarily, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Receivables: Receivables are reported net of amounts for expected credit losses. The allowance for doubtful accounts is based on historical collection trends, future forecasts and our judgment regarding the ability to collect specific accounts.

Premium receivables include the uncollected amounts from employer risk-based groups, individuals and government programs for insurance services. Premium receivables are reported net of an allowance for doubtful accounts of $188 and $152 at September 30, 2023 and December 31, 2022, respectively.

Self-funded receivables include administrative fees, claims and other amounts due from fee-based customers for administrative services. Self-funded receivables are reported net of an allowance for doubtful accounts of $93 and $68 at September 30, 2023 and December 31, 2022, respectively.

Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance receivables, proceeds due from brokers on investment trades, accrued investment income and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of $875 and $744 at September 30, 2023 and December 31, 2022, respectively.

Revenue Recognition: For our non-risk-based contracts, we had no material contract assets, contract liabilities or deferred contract costs recorded on our consolidated balance sheet at September 30, 2023. For the three and nine months ended September 30, 2023 and 2022, revenue recognized from performance obligations related to prior periods, such as changes in transaction price, were not material. For contracts that have an original, expected duration of greater than one year, revenue expected to be recognized in future periods related to unfulfilled contractual performance obligations and contracts with variable consideration related to undelivered performance obligations is not material.

Recently Adopted Accounting Guidance: In November 2020, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update No. 2020-11, *Financial Services—Insurance (Topic 944): Effective Date and Early Application* ("ASU 2020-11"). The amendments in ASU 2020-11 change the effective date and early application of Accounting Standards Update No. 2018-12, *Financial Services—Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts*, which was issued in November 2018. The amendments in ASU 2020-11 extended the original effective date by one year, and now the amendments are required for our interim and annual reporting periods beginning after December 15, 2022. This standard requires us to review cash flow assumptions for our long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. This standard also requires us to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount our reserves for future policy benefits will be based on an estimate of the yield for an upper-medium grade fixed-income instrument with a duration profile matching that of our liabilities. In addition, this standard changes the amortization method for deferred acquisition costs. We adopted these amendments on January 1, 2023, using the modified retrospective transition method for changes to the liability for future policy benefits and deferred acquisition costs as of the transition date, January 1, 2021. While the adoption did not have an overall material impact, our prior period financial statements presented in this Form 10-Q have been restated to reflect the impacts of our adoption as required by the new standard.

Recent Accounting Guidance Not Yet Adopted: In August 2023, the FASB issued Accounting Standards Update No. 2023-05, *Business Combinations—Joint Venture Formations (Subtopic 805-60): Recognition and Initial Measurement* ("ASU 2023-05"). ASU 2023-05 clarifies existing guidance to reduce diversity in practice and is requiring a joint venture to recognize and initially measure its assets and liabilities using a new basis of accounting, at fair value, upon formation. These amendments are effective prospectively for all joint venture formations with a formation date on or after January 1, 2025. We do not believe the adoption of ASU 2023-05 will have a material impact on our consolidated financial statements and disclosures.

There were no other new accounting pronouncements that were issued or became effective since December 31, 2022 that had, or are expected to have, a material impact on our consolidated financial position, results of operations or cash flows.

3. Business Acquisitions and Divestitures

Pending Divestiture

On March 28, 2023, we announced our entrance into an agreement to sell our life and disability businesses to StanCorp Financial Group, Inc. ("The Standard"), a provider of financial protection products and services for employers and individuals. Upon closing, we and The Standard will enter into a product distribution partnership. The divestiture is expected to close in the first half of 2024 and is subject to standard closing conditions and customary approvals. The related net assets held for sale and results of operations for the life and disability businesses to be divested as of and for the three and nine months ending September 30, 2023 were not material.

Pending Acquisition

On January 23, 2023, we announced our entrance into an agreement to acquire Louisiana Health Service & Indemnity Company, d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), an independent licensee of the BCBSA that provides healthcare plans to the Individual, Employer Group, Medicaid and Medicare markets, primarily in the State of Louisiana. This acquisition aligns with our mission to become a lifetime, trusted health partner as we bring our innovative whole-health solutions to BCBSLA's members. The acquisition is expected to close in the first half of 2024 and is subject to standard closing conditions and customary approvals.

Completed Acquisitions

On February 15, 2023, we completed our acquisition of BioPlus Parent, LLC and subsidiaries ("BioPlus") from CarepathRx Aggregator, LLC. Prior to the acquisition, BioPlus was one of the largest independent specialty pharmacy organizations in the United States. BioPlus, which operates as part of CarelonRx, seeks to connect payors and providers of specialty pharmaceuticals to meet the medication therapy needs of patients with complex medical conditions. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. As of September 30, 2023, the purchase price was allocated to the tangible and intangible net assets acquired based on management's initial estimates of their fair values, of which $820 has been allocated to finite-lived intangible assets and $877 to goodwill. There were no changes to goodwill for measurement period adjustments during the three months ended September 30, 2023. The majority of goodwill is not deductible for income tax purposes. As of September 30, 2023, the initial accounting for the acquisition had not been finalized. The proforma effects of this acquisition for prior periods were not material to our consolidated results of operations.

On May 5, 2022, we completed our acquisition of Integra Managed Care ("Integra"). Integra is a managed long-term care plan that serves New York state Medicaid members, enabling adults with long-term care needs and disabilities to live safely and independently in their own homes. The initial accounting for this acquisition was finalized as of June 30, 2023. The purchase price was allocated to tangible and intangible net assets acquired based on management's estimates of their fair values, of which $89 was allocated to finite-lived intangible assets, $250 to indefinite-lived intangible assets, and $139 to goodwill. The majority of goodwill is deductible for income tax purposes. The proforma effects of this acquisition for prior periods were not material to our consolidated results of operations.

4. Business Optimization Initiatives

During the third quarter of 2023, based on a strategic review of our operations, assets and investments, management implemented the "2023-2024 Business Efficiency Program" to enhance operating efficiency, refine the focus of our investments, and optimize our physical footprint. The 2023-2024 Business Efficiency Program includes the write-off of certain information technology assets and contract exit costs, a reduction in staff including the relocation of certain job functions, and the impairment of assets associated with the closure or partial closure of data centers and offices. The 2023-2024 Business Efficiency Program is expected to be substantially complete by the end of the third quarter of 2024. Cash outlays associated with this program, which primarily relate to the personnel-related costs, are expected to be paid through 2024.

In the third quarter of 2023, we incurred $730 of costs towards the 2023-2024 Business Efficiency Program. This included $446 of pre-tax charges for information technology assets and contract write-offs related to projects that have been de-prioritized and stopped, $230 of pre-tax personnel-related charges for the reduction and/or relocation of staff, which includes severance and related costs primarily determined under the Company's existing severance plans, and $54 of pre-tax charges from asset impairments related to the closure or partial closure of data centers and offices, including operating lease-related right-of-use assets and other property and equipment. These charges were recognized in operating expense in the Corporate & Other segment; see Note 15, "Segment Information."

In the third quarter of 2023, we also released $33 of severance related accruals from our business optimization initiatives introduced in 2020 ("2020 Business Optimization Initiatives"). A summary of the activity for the nine months ended September 30, 2023 and ending balance at September 30, 2023 related to the liability for employee termination costs, is as follows:

	Health Benefits	CarelonRx	Carelon Services	Corporate & Other	Total
2023-2024 Business Efficiency Program					
Liabilities for employee termination costs at January 1, 2023	$ —	$ —	$ —	$ —	$ —
Charges	—	—	—	230	230
Payments and releases	—	—	—	—	—
Total liabilities for employee termination costs ending balance at September 30, 2023	$ —	$ —	$ —	$ 230	$ 230

	Health Benefits	CarelonRx	Carelon Services	Corporate & Other	Total
2020 Business Optimization Initiatives					
Liabilities for employee termination costs at January 1, 2023	$ 80	$ 1	$ —	$ —	$ 81
Payments	(31)	(1)	—	—	(32)
Releases	(33)	—	—	—	(33)
Total liabilities for employee termination costs ending balance at September 30, 2023	$ 16	$ —	$ —	$ —	$ 16

5. Investments

Fixed Maturity Securities

We evaluate our available-for-sale fixed maturity securities for declines based on qualitative and quantitative factors. We have established an allowance for credit loss and recorded credit loss expense as a reflection of our expected impairment losses. We continue to review our investment portfolios under our impairment review policy. Given the inherent uncertainty of changes in market conditions and the significant judgments involved, there is a continuing risk that declines in fair value may occur and additional material impairment losses for credit losses on investments may be recorded in future periods.

A summary of current and long-term fixed maturity securities, available-for-sale, at September 30, 2023 and December 31, 2022 is as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Allowance For Credit Losses	Estimated Fair Value
September 30, 2023					
Fixed maturity securities:					
United States Government securities	$ 1,906	$ —	$ (129)	$ —	$ 1,777
Government sponsored securities	110	—	(8)	—	102
Foreign government securities	14	—	(2)	—	12
States, municipalities and political subdivisions, tax-exempt	3,898	6	(325)	—	3,579
Corporate securities	14,548	22	(1,156)	(1)	13,413
Residential mortgage-backed securities	3,876	6	(438)	—	3,444
Commercial mortgage-backed securities	2,153	1	(188)	(2)	1,964
Other asset-backed securities	4,508	17	(189)	—	4,336
Total fixed maturity securities	$ 31,013	$ 52	$ (2,435)	$ (3)	$ 28,627
December 31, 2022					
Fixed maturity securities:					
United States Government securities	$ 1,502	$ 2	$ (103)	$ —	$ 1,401
Government sponsored securities	82	1	(5)	—	78
Foreign government securities	321	1	(46)	(2)	274
States, municipalities and political subdivisions, tax-exempt	4,389	19	(265)	—	4,143
Corporate securities	13,721	31	(1,218)	(5)	12,529
Residential mortgage-backed securities	2,978	9	(324)	—	2,663
Commercial mortgage-backed securities	2,055	1	(176)	(2)	1,878
Other asset-backed securities	3,967	12	(241)	—	3,738
Total fixed maturity securities	$ 29,015	$ 76	$ (2,378)	$ (9)	$ 26,704

Other asset-backed securities primarily consists of collateralized loan obligations and other debt securities.

For fixed maturity securities in an unrealized loss position at September 30, 2023 and December 31, 2022, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position:

	Less than 12 Months			12 Months or Greater		
(Securities are whole amounts)	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
September 30, 2023						
Fixed maturity securities:						
United States Government securities	55	$ 1,170	$ (58)	55	$ 423	$ (71)
Government sponsored securities	6	50	(2)	40	52	(6)
Foreign government securities	5	5	—	5	7	(2)
States, municipalities and political subdivisions, tax-exempt	833	1,503	(55)	1,132	1,876	(270)
Corporate securities	2,160	4,995	(180)	2,908	7,542	(976)
Residential mortgage-backed securities	583	1,339	(59)	1,583	1,895	(379)
Commercial mortgage-backed securities	176	517	(22)	579	1,395	(166)
Other asset-backed securities	323	1,154	(50)	879	2,577	(139)
Total fixed maturity securities	4,141	$ 10,733	$ (426)	7,181	$ 15,767	$ (2,009)
December 31, 2022						
Fixed maturity securities:						
United States Government securities	61	$ 701	$ (40)	38	$ 442	$ (63)
Government sponsored securities	39	73	(4)	6	5	(1)
Foreign government securities	150	100	(10)	198	142	(36)
States, municipalities and political subdivisions, tax-exempt	1,398	2,615	(147)	396	652	(118)
Corporate securities	3,551	7,826	(549)	2,204	3,521	(669)
Residential mortgage-backed securities	1,341	1,435	(121)	496	982	(203)
Commercial mortgage-backed securities	457	1,082	(76)	324	719	(100)
Other asset-backed securities	784	2,203	(124)	398	1,074	(117)
Total fixed maturity securities	7,781	$ 16,035	$ (1,071)	4,060	$ 7,537	$ (1,307)

Unrealized losses on our securities shown in the table above have not been recognized into income because, as of September 30, 2023, we do not intend to sell these investments and it is likely that we will not be required to sell these investments prior to their maturity or anticipated recovery. The declines in fair values are largely due to increasing interest rates driven by the higher rate of inflation and other market conditions.

Allowances for credit losses have been recorded in the amounts of $3 and $9 at September 30, 2023 and December 31, 2022, respectively, for declines in fair value due to unfavorable changes in the credit quality characteristics that impact our assessment of collectability of principal and interest.

The amortized cost and fair value of fixed maturity securities at September 30, 2023, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 757	$ 749
Due after one year through five years	8,146	7,729
Due after five years through ten years	10,062	9,300
Due after ten years	6,019	5,441
Mortgage-backed securities	6,029	5,408
Total fixed maturity securities	$ 31,013	$ 28,627

During the three and nine months ended September 30, 2023, we received total proceeds from sales, maturities, calls or redemptions of fixed maturity securities of $6,236 and $21,321, respectively. During the three and nine months ended September 30, 2022, we received total proceeds from sales, maturities, calls or redemptions of fixed maturity securities of $5,281 and $15,953, respectively.

In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectation that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

Equity Securities

A summary of marketable equity securities at September 30, 2023 and December 31, 2022 is as follows:

	September 30, 2023	December 31, 2022
Equity securities:		
Exchange traded funds	$ 56	$ 822
Common equity securities	40	43
Private equity securities	69	88
Total	$ 165	$ 953

Other Invested Assets

Other invested assets include primarily our investments in limited partnerships, joint ventures and other non-controlled corporations, mortgage loans and the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. Financial information for certain of these investments is reported on a one or three month lag due to the timing of when we receive financial information from the companies.

Investment Gains and Losses

Net investment (losses) gains for the three and nine months ended September 30, 2023 and 2022 are as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2023	2022	2023	2022
Net (losses) gains:				
Fixed maturity securities:				
Gross realized gains from sales	$ 13	$ 8	$ 34	$ 44
Gross realized losses from sales	(164)	(99)	(377)	(353)
Impairment recoveries (losses) recognized in income	2	(5)	(8)	(25)
Net realized losses from sales of fixed maturity securities	(149)	(96)	(351)	(334)
Equity securities:				
Unrealized losses recognized on equity securities still held at the end of the period	—	(43)	(1)	(192)
Net realized gains (losses) recognized on equity securities sold during the period	2	4	5	(20)
Net gains (losses) on equity securities	2	(39)	4	(212)
Other investments:				
Gross gains	86	95	91	126
Gross losses	(68)	(2)	(62)	(45)
Impairment losses recognized in income	(8)	(12)	(37)	(17)
Net gains (losses) on other investments	10	81	(8)	64
Net losses on investments	$ (137)	$ (54)	$ (355)	$ (482)

Accrued Investment Income

At September 30, 2023 and December 31, 2022, accrued investment income totaled $281 and $245, respectively. We recognize accrued investment income under the caption “Other receivables” on our consolidated balance sheets.

Securities Lending Programs

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. The fair value of the collateral received at the time of the transactions amounted to $2,403 and $2,457 at September 30, 2023 and December 31, 2022, respectively. The value of the collateral represented 102% of the market value of the securities on loan at each of September 30, 2023 and December 31, 2022. We recognize the collateral as an asset under the caption “Other current assets” in our consolidated balance sheets, and we recognize a corresponding liability for the obligation to return the collateral to the borrower under the caption “Other current liabilities.” The securities on loan are reported in the applicable investment category on our consolidated balance sheets.

At September 30, 2023 and December 31, 2022, the remaining contractual maturity of our securities lending agreements included overnight and continuous transactions of cash for $2,266 and $2,221, respectively, of United States Government securities for $92 and $224, respectively, of States, Municipalities, and Political Subdivisions securities for $7 and $0, respectively, and of Residential Mortgage-Backed securities for $38 and $12, respectively.

6. Derivative Financial Instruments

We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. We also enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions.

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to the Secured Overnight Financing Rate ("SOFR"). Any amounts recognized for changes in fair value of these derivatives are included in the captions "Other current assets," "Other noncurrent assets," "Other current liabilities" or "Other noncurrent liabilities" in our consolidated balance sheets.

The unrecognized loss for all expired and terminated cash flow hedges included in accumulated other comprehensive loss, net of tax, was $213 and $229 at September 30, 2023 and December 31, 2022, respectively.

During the three and nine months ended months ended September 30, 2023, we recognized net gains of $13 and net losses of $3, respectively, on non-hedging derivatives. During the three and nine months ended months ended September 30, 2022, we recognized net losses of $3 and net gains of $43 on non-hedging derivatives, respectively.

For additional information relating to the fair value of our derivative assets and liabilities, see Note 7, "Fair Value," of this Form 10-Q.

7. Fair Value

Assets and liabilities recorded at fair value in our consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input	Input Definition
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in our consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions, mortgage-backed securities, United States government securities, foreign government securities, and certain other asset-backed securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily collateralized loan obligation securities and corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available, and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, and/or revenue multiples that are not observable in the markets.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate observable market inputs for similar derivative transactions. Derivatives are designated as Level II securities. Derivatives presented within the fair value hierarchy table below are presented on a gross basis and not on a master netting basis by counterparty.

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at September 30, 2023 and December 31, 2022 is as follows:

	Level I	Level II	Level III	Total
September 30, 2023				
Assets:				
Cash equivalents	$ 7,036	$ —	$ —	$ 7,036
Fixed maturity securities, available-for-sale:				
United States Government securities	—	1,777	—	1,777
Government sponsored securities	—	102	—	102
Foreign government securities	—	12	—	12
States, municipalities and political subdivisions, tax-exempt	—	3,579	—	3,579
Corporate securities	—	13,303	110	13,413
Residential mortgage-backed securities	—	3,442	2	3,444
Commercial mortgage-backed securities	—	1,964	—	1,964
Other asset-backed securities	—	3,917	419	4,336
Total fixed maturity securities, available-for-sale	—	28,096	531	28,627
Equity securities:				
Exchange traded funds	56	—	—	56
Common equity securities	11	29	—	40
Private equity securities	—	—	69	69
Total equity securities	67	29	69	165
Other invested assets - common equity securities	102	—	—	102
Securities lending collateral	—	2,405	—	2,405
Derivatives - other assets	—	11	—	11
Total assets	$ 7,205	$ 30,541	$ 600	$ 38,346
Liabilities:				
Derivatives - other liabilities	$ —	$ (92)	$ —	$ (92)
Total liabilities	$ —	$ (92)	$ —	$ (92)
December 31, 2022				
Assets:				
Cash equivalents	$ 3,567	$ —	$ —	$ 3,567
Fixed maturity securities, available-for-sale:				
United States Government securities	—	1,401	—	1,401
Government sponsored securities	—	78	—	78
Foreign government securities	—	274	—	274
States, municipalities and political subdivisions, tax-exempt	—	4,143	—	4,143
Corporate securities	—	12,392	137	12,529
Residential mortgage-backed securities	—	2,663	—	2,663
Commercial mortgage-backed securities	—	1,878	—	1,878
Other asset-backed securities	—	3,382	356	3,738
Total fixed maturity securities, available-for-sale	—	26,211	493	26,704
Equity securities:				
Exchange traded funds	822	—	—	822
Common equity securities	2	41	—	43
Private equity securities	—	—	88	88
Total equity securities	824	41	88	953
Other invested assets - common equity securities	103	—	—	103
Securities lending collateral	—	2,457	—	2,457
Derivatives - other assets	—	3	—	3
Total assets	$ 4,494	$ 28,712	$ 581	$ 33,787
Liabilities:				
Derivatives - other liabilities	$ —	$ (60)	$ —	$ (60)
Total liabilities	$ —	$ (60)	$ —	$ (60)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the three months ended September 30, 2023 and 2022 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Other Asset-backed Securities	Equity Securities	Total
Three Months Ended September 30, 2023					
Beginning balance at July 1, 2023	$ 103	$ —	$ 366	$ 75	$ 544
Total gains (losses):					
Recognized in net income	(2)	—	—	2	—
Recognized in accumulated other comprehensive loss	1	—	—	—	1
Purchases	17	—	60	3	80
Sales	(2)	—	(6)	(11)	(19)
Settlements	(12)	—	—	—	(12)
Transfers into Level III	6	2	—	—	8
Transfers out of Level III	(1)	—	(1)	—	(2)
Ending balance at September 30, 2023	$ 110	$ 2	$ 419	$ 69	$ 600
Change in unrealized gains (losses) included in net income related to assets still held at September 30, 2023	$ —	$ —	$ —	$ —	$ —
Three Months Ended September 30, 2022					
Beginning balance at July 1, 2022	$ 155	$ —	$ 218	$ 94	$ 467
Total gains (losses):					
Recognized in net income	—	—	—	—	—
Recognized in accumulated other comprehensive loss	1	—	17	—	18
Purchases	15	—	77	3	95
Sales	(26)	—	(1)	(2)	(29)
Settlements	(10)	—	—	—	(10)
Transfers into Level III	—	—	—	—	—
Transfers out of Level III	(6)	—	—	—	(6)
Ending balance at September 30, 2022	$ 129	$ —	$ 311	$ 95	$ 535
Change in unrealized gains (losses) included in net income related to assets still held at September 30, 2022	$ —	$ —	$ —	$ —	$ —

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the nine months ended September 30, 2023 and 2022 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Other Asset-backed Securities	Equity Securities	Total
Nine Months Ended September 30, 2023					
Beginning balance at January 1, 2023	$ 137	$ —	$ 356	$ 88	$ 581
Total gains (losses):					
Recognized in net income	(8)	—	—	(3)	(11)
Recognized in accumulated other comprehensive loss	5	—	2	—	7
Purchases	22	—	72	4	98
Sales	(43)	—	(17)	(20)	(80)
Settlements	(18)	—	—	—	(18)
Transfers into Level III	35	2	6	—	43
Transfers out of Level III	(20)	—	—	—	(20)
Ending balance at September 30, 2023	$ 110	$ 2	$ 419	$ 69	$ 600
Change in unrealized losses included in net income related to assets still held at September 30, 2023	$ —	$ —	$ —	$ (4)	$ (4)
Nine Months Ended September 30, 2022					
Beginning balance at January 1, 2022	$ 336	$ 5	$ 19	$ 89	$ 449
Total gains (losses):					
Recognized in net income	—	—	—	1	1
Recognized in accumulated other comprehensive loss	(1)	—	17	—	16
Purchases	40	—	281	24	345
Sales	(201)	—	(1)	(19)	(221)
Settlements	(42)	—	—	—	(42)
Transfers into Level III	9	—	—	—	9
Transfers out of Level III	(12)	(5)	(5)	—	(22)
Ending balance at September 30, 2022	$ 129	$ —	$ 311	$ 95	$ 535
Change in unrealized gains included in net income related to assets still held at September 30, 2022	$ —	$ —	$ —	$ 1	$ 1

There were no individually material transfers into or out of Level III during the three and nine months ended September 30, 2023 or 2022.

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, “Business Acquisitions and Divestitures,” we completed our acquisition of BioPlus in the first quarter of 2023 and Integra during the second quarter of 2022. The net assets acquired in our acquisitions of BioPlus and Integra and resulting goodwill and other intangible assets were recorded at fair value primarily using Level III inputs. The majority of tangible assets acquired and liabilities assumed were recorded at their carrying values as of the acquisition date, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in our acquisitions of BioPlus and Integra were internally estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation. Other than the assets acquired and liabilities assumed in our acquisitions of BioPlus and Integra described above, there were no material assets or liabilities measured at fair value on a nonrecurring basis during the three and nine months ended September 30, 2023 or 2022.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes, unobservable inputs or other valuation techniques. These techniques are significantly affected by our assumptions, including discount rates and estimates of future cash flows. The use of assumptions for unobservable inputs for the determination of fair value involves a level of judgment and uncertainty. Changes in assumptions that reasonably could have been different at the reporting date may result in a higher or lower determination of fair value. Changes in fair value measurements, if significant, may affect performance of cash flows.

Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain quoted prices for each security from third-party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the three and nine months ended September 30, 2023 or 2022.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in our consolidated balance sheets.

Non-financial instruments such as property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, premium receivables, self-funded receivables, other receivables, unearned income, accounts payable and accrued expenses, and certain other current liabilities approximate fair value because of the short-term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value in our consolidated balance sheets:

Other invested assets: Other invested assets include primarily our investments in limited partnerships, joint ventures and other non-controlled corporations and mortgage loans, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. Mortgage loans are carried at amortized cost, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or, if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities. The carrying amount for commercial paper approximates fair value, as the underlying instruments have variable interest rates at market value.

Long-term debt—senior unsecured notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at September 30, 2023 and December 31, 2022 is as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
September 30, 2023					
Assets:					
Other invested assets	$ 6,016	$ —	$ —	$ 6,016	$ 6,016
Liabilities:					
Debt:					
Notes	24,844	—	21,815	—	21,815
December 31, 2022					
Assets:					
Other invested assets	$ 5,582	$ —	$ —	$ 5,582	$ 5,582
Liabilities:					
Debt:					
Short-term borrowings	265	—	265	—	265
Notes	23,786	—	21,861	—	21,861
Convertible debentures	63	—	463	—	463

8. Income Taxes

During the three months ended September 30, 2023 and 2022, we recognized income tax expense of $354 and $529 (restated), respectively, which represent effective income tax rates of 21.4% and 24.9% (restated), respectively. The decrease in our effective income tax rate from the three months ended September 30, 2022 is primarily due to the tax impact of expected geographic changes in our mix of 2023 earnings.

During the nine months ended September 30, 2023 and 2022, we recognized income tax expense of $1,554 and $1,544 (restated), respectively, which represent effective income tax rates of 23.1% and 23.6% (restated), respectively. The decrease in our effective income tax rate from the nine months ended September 30, 2022 is primarily related to the tax impact of expected geographic changes in our mix of 2023 earnings.

Income taxes receivable totaled $258 and $440 at September 30, 2023 and December 31, 2022, respectively. At September 30, 2023, we recognized the income tax receivable as $183 under the caption “Other current assets” and as $75 under the caption “Other noncurrent assets”.

9. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable for the nine months ended September 30, 2023 and 2022 is as follows:

	2023	2022
Gross medical claims payable, beginning of period	$ 15,348	$ 13,282
Ceded medical claims payable, beginning of period	(6)	(21)
Net medical claims payable, beginning of period	15,342	13,261
Business combinations and purchase adjustments	—	133
Net incurred medical claims:		
Current period	91,058	84,177
Prior periods redundancies	(1,342)	(901)
Total net incurred medical claims	89,716	83,276
Net payments attributable to:		
Current period medical claims	77,048	70,453
Prior periods medical claims	12,097	11,219
Total net payments	89,145	81,672
Net medical claims payable, end of period	15,913	14,998
Ceded medical claims payable, end of period	4	3
Gross medical claims payable, end of period	$ 15,917	$ 15,001

At September 30, 2023, the total of net incurred but not reported liabilities plus expected development on reported claims was $481, $1,421 and $14,011 for the claim years 2021 and prior, 2022 and 2023, respectively.

The favorable development recognized in the nine months ended September 30, 2023 resulted from trend factors in late 2022 developing more favorably than originally expected and completion factors in the latter parts of 2022 developing faster than expected. The favorable development recognized in the nine months ended September 30, 2022 resulted primarily from trend factors in late 2021 developing more favorably than originally expected.

The reconciliation of net incurred medical claims to benefit expense included in our consolidated statements of income for the periods in 2023 is as follows:

	Three Months Ended			Nine Months Ended
	March 31, 2023	June 30, 2023	September 30, 2023	September 30, 2023
Total net incurred medical claims	$ 29,683	$ 30,495	$ 29,538	$ 89,716
Quality improvement and other claims expense	1,103	1,109	1,068	3,280
Benefit expense	$ 30,786	$ 31,604	$ 30,606	$ 92,996

The reconciliation of net incurred medical claims to benefit expense included in our consolidated statements of income for the periods in 2022 is as follows:

	Three Months Ended			Nine Months Ended
	March 31, 2022	June 30, 2022	September 30, 2022	September 30, 2022
	(Restated)	(Restated)	(Restated)	(Restated)
Total net incurred medical claims	$ 27,131	$ 27,634	$ 28,511	$ 83,276
Quality improvement and other claims expense	1,100	1,161	910	3,171
Benefit expense	$ 28,231	$ 28,795	$ 29,421	$ 86,447

The reconciliation of the medical claims payable reflected in the tables above to the consolidated ending balance for medical claims payable included in the consolidated balance sheet, as of September 30, 2023 and December 31, 2022, is as follows:

	September 30, 2023	December 31, 2022
Net medical claims payable, end of period	$ 15,913	$ 15,342
Ceded medical claims payable, end of period	4	6
Insurance lines other than short duration	259	248
Gross medical claims payable, end of period	$ 16,176	$ 15,596

10. Debt

We generally issue senior unsecured notes for long-term borrowing purposes. At September 30, 2023 and December 31, 2022, we had $24,819 and $23,761, respectively, outstanding under these notes.

On February 8, 2023, we issued $500 aggregate principal amount of 4.900% Notes due 2026 (the "2026 Notes"), $1,000 aggregate principal amount of 4.750% Notes due 2033 (the "2033 Notes"), and $1,100 aggregate principal amount of 5.125% Notes due 2053 (the "2053 Notes") under our shelf registration statement. Interest on the 2026 Notes is payable semi-annually in arrears on February 8 and August 8 of each year, commencing August 8, 2023. Interest on the 2033 Notes and 2053 Notes is payable semi-annually in arrears on February 15 and August 15 of each year, commencing August 15, 2023. We intend to use the proceeds for working capital and general corporate purposes, including, but not limited to, the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

On January 17, 2023, we repaid, at maturity, the $1,000 outstanding balance of our 3.300% senior unsecured notes. On March 15, 2023, we repaid, at maturity, the $500 outstanding balance of our 0.450% senior unsecured notes.

We have an unsecured surplus note with an outstanding principal balance of $25 at both September 30, 2023 and December 31, 2022.

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. The 5-Year Facility provides credit of up to $4,000 and matures in April 2027. Our ability to borrow under the 5-Year Facility is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the credit agreement for the 5-Year Facility. As of September 30, 2023, our debt-to-capital ratio, as defined and calculated under the 5-Year Facility, was 39.2%. We do not believe the restrictions contained in our 5-Year Facility covenants materially affect our financial or operating flexibility. As of September 30, 2023, we were in compliance with all of our debt covenants under the 5-Year Facility. There were no amounts outstanding under the 5-Year Facility at any time during the nine months ended September 30, 2023 or the year ended December 31, 2022.

We have an authorized commercial paper program of up to $4,000, the proceeds of which may be used for general corporate purposes. At both September 30, 2023 and December 31, 2022, we had no amounts outstanding under this program. Beginning June 30, 2023, we have reclassified our commercial paper balances from long-term debt to short-term debt as our intent is to not replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year.

On March 15, 2023, we redeemed all of our outstanding senior unsecured convertible debentures due 2042 (the "Debentures"), pursuant to the indenture dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee. The Debentures were redeemed at a redemption price equal to 100% of the principal amount of the Debentures plus accrued and unpaid interest to, but excluding, the date of redemption, for cash totaling $5. During the three months ended March 31, 2023, $59 of aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and conditions of the indenture. We elected to settle the excess of the principal amount of the conversions with cash for total payments during the three months ended March 31, 2023 of $404.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York (collectively, the "FHLBs"). As a member, we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. We had $0 and $265 of outstanding short-term borrowings from the FHLBs at September 30, 2023 and December 31, 2022, respectively.

All debt is a direct obligation of Elevance Health, Inc., except for the surplus note and the FHLBs borrowings.

11. Commitments and Contingencies

Litigation and Regulatory Proceedings

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint, or in other court filings, the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves is, in the aggregate, from $0 to approximately $250 at September 30, 2023. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Blue Cross Blue Shield Antitrust Litigation

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA and Blue Cross and/or Blue Shield licensees (the "Blue plans") across the country. Cases filed in 28 states were consolidated into a single, multi-district proceeding captioned *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the U.S. District Court for the Northern District of Alabama (the "Court"). Generally, the suits allege that the BCBSA and the Blue plans have conspired to horizontally allocate geographic markets through license agreements, best efforts rules that limit the percentage of non-Blue revenue of each plan, restrictions on acquisitions, rules governing the BlueCard® and National Accounts programs and other arrangements in violation of the Sherman Antitrust Act ("Sherman Act") and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers.

In April 2018, the Court issued an order on the parties' cross motions for partial summary judgment, determining that the defendants' aggregation of geographic market allocations and output restrictions are to be analyzed under a per se standard of review, and the BlueCard® program and other alleged Section 1 Sherman Act violations are to be analyzed under the rule of reason standard of review. With respect to whether the defendants operate as a single entity with regard to the enforcement of the Blue Cross Blue Shield trademarks, the Court found that summary judgment was not appropriate due to the existence of genuine issues of material fact. In April 2019, the plaintiffs filed motions for class certification, which defendants opposed.

The BCBSA and Blue plans approved a settlement agreement and release with the subscriber plaintiffs (the "Subscriber Settlement Agreement"), which agreement required the Court's approval to become effective. The Subscriber Settlement Agreement requires the defendants to make a monetary settlement payment and contains certain terms imposing non-monetary obligations including (i) eliminating the "national best efforts" rule in the BCBSA license agreements (which rule limits the percentage of non-Blue revenue permitted for each Blue plan) and (ii) allowing for some large national employers with self-funded benefit plans to request a bid for insurance coverage from a second Blue plan in addition to the local Blue plan.

In November 2020, the Court issued an order preliminarily approving the Subscriber Settlement Agreement, following which members of the subscriber class were provided notice of the Subscriber Settlement Agreement and an opportunity to opt out of the class. A small number of subscribers submitted valid opt-outs by the opt-out deadline.

In August 2022, the Court issued a final order approving the Subscriber Settlement Agreement (the "Final Approval Order"). The Court amended its Final Approval Order in September 2022, further clarifying the injunctive relief that may be available to subscribers who submitted valid opt-outs. In compliance with the Subscriber Settlement Agreement, the Company paid $506 into an escrow account in September 2022, for an aggregate and full settlement payment by the Company of $596, which amount was accrued in 2020.

Four notices of appeal of the Final Approval Order were filed prior to the September 2022 appeal deadline. Those appeals were heard by a panel of the United States Court of Appeals for the Eleventh Circuit in September 2023. In the event that all appellate rights are exhausted in a manner that affirms the Court's Final Approval Order, the defendants' payment and non-monetary obligations under the Subscriber Settlement Agreement will become effective and the funds held in escrow will be distributed in accordance with the Subscriber Settlement Agreement.

In October 2020, after the Court lifted the stay as to the provider litigation, provider plaintiffs filed a renewed motion for class certification, which defendants opposed. In March 2021, the Court issued an order terminating the pending motion for class certification until the Court determined the standard of review applicable to the providers' claims. In response to that order, the parties filed renewed standard of review motions in May 2021. In June 2021, the parties filed summary judgment motions not critically dependent on class certification. In February 2022, the Court issued orders (i) granting certain defendants' motion for partial summary judgment against the provider plaintiffs who had previously released claims against such defendants, and (ii) granting the provider plaintiffs' motion for partial summary judgment, determining that *Ohio v. American Express Co*. does not affect the standard of review in this case. In August 2022, the Court issued orders (i) granting in part the defendants' motion regarding the antitrust standard of review, holding that for the period of time after the elimination of the "national best efforts" rule, the rule of reason applies to the provider plaintiffs' market allocation conspiracy claims, and (ii) denying the provider plaintiffs' motion for partial summary judgment on the standard of review, reaffirming its prior holding that the provider groups' boycott claims are subject to the rule of reason. In November 2022, the Court issued an order requiring the parties to submit supplemental briefs on certain questions related to the providers' renewed motion for class certification. We intend to continue to vigorously defend the provider litigation, which we believe is without merit; however, its ultimate outcome cannot be presently determined.

A number of follow-on cases involving entities that opted out of the Subscriber Settlement Agreement have been filed. Those actions are: *Alaska Air Group, Inc., et al. v. Anthem, Inc., et al.,* No. 2:21-cv-01209-AMM (N.D. Ala.) (*"Alaska Air"*); *JetBlue Airways Corp., et al. v. Anthem, Inc., et al.*, No. 2:22-cv-00558-GMB (N.D. Ala.) (*"Jet Blue"*); *Metropolitan Transportation Authority v. Blue Cross and Blue Shield of Alabama et al.*, No. 2:22-cv-00265-RDP (N.D. Ala.); *Bed Bath & Beyond Inc. v. Anthem, Inc.*, No. 2:22-cv-01256-SGC (N.D. Ala.) (*"Bed Bath & Beyond"*); *Hoover, et al. v. Blue Cross Blue Shield Association, et al.*, No. 2:22-cv-00261-RDP (N.D. Ala.); and *VHS Liquidating Trust v. Blue Cross of California, et al.*, No. RG21106600 (Cal. Super.). In February 2023, the Court denied the defendants' motion to dismiss based on a statute of limitations defense in *Alaska Air* and *Jet Blue*. In March 2023, pursuant to a stipulation by the parties, the Court denied the defendants' motion to dismiss also based on a statute of limitations defense in *Bed Bath & Beyond*. We intend to continue to vigorously defend these follow-on cases, which we believe are without merit; however, their ultimate outcome cannot be presently determined.

Blue Cross of California Taxation Litigation

In July 2013, our California affiliate Blue Cross of California (doing business as Anthem Blue Cross) ("BCC") was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court (the "Superior Court")

captioned *Michael D. Myers v. State Board of Equalization, et al.* This action was brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that BCC, a licensed Health Care Service Plan, is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. At the time, under California law, "insurers" were required to pay a gross premiums tax ("GPT") calculated as 2.35% on gross premiums. As a licensed Health Care Service Plan, BCC has paid the California Corporate Franchise Tax ("CFT"), the tax paid by California businesses generally. Plaintiff contends that BCC must pay the GPT rather than the CFT and seeks a writ of mandate directing the taxing agencies to collect the GPT and an order requiring BCC to pay GPT back taxes, interest, and penalties for the eight-year period prior to the filing of the complaint.

Because the GPT is constitutionally imposed in lieu of certain other taxes, BCC has filed protective tax refund claims with the City of Los Angeles, the California Department of Health Care Services and the Franchise Tax Board to protect its rights to recover certain taxes previously paid should BCC eventually be determined to be subject to the GPT for the tax periods at issue in the litigation.

In December 2020, the Superior Court granted BCC's motion for summary judgment, dismissing the plaintiff's lawsuit. In November 2021, the plaintiff appealed the summary judgment order. In March 2023, the appeal was argued before the California Second District Court of Appeal (the "Second District"). The Second District affirmed the Superior Court's summary judgment order in April 2023. The plaintiff filed a petition for review with the California Supreme Court in June 2023, and BCC filed its answer to the petition in the same month. In July 2023, the California Supreme Court denied the plaintiff's petition for review. This matter is now resolved, and the protective tax refund claims mentioned above have been withdrawn.

Express Scripts, Inc. Pharmacy Benefit Management Litigation

In March 2016, we filed a lawsuit against Express Scripts, Inc. ("Express Scripts"), our vendor at the time for pharmacy benefit management services, captioned *Anthem, Inc. v. Express Scripts, Inc.*, in the U.S. District Court for the Southern District of New York (the "District Court"). The lawsuit seeks to recover over $14,800 in damages for pharmacy pricing that is higher than competitive benchmark pricing under the agreement between the parties (the "ESI Agreement"), over $158 in damages related to operational breaches, as well as various declarations under the ESI Agreement, including that Express Scripts: (i) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (ii) was required to provide competitive benchmark pricing to us through the term of the ESI Agreement; (iii) has breached the ESI Agreement; and (iv) is required under the ESI Agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination.

Express Scripts has disputed our contractual claims and is seeking declaratory judgments: (i) regarding the timing of the periodic pricing review under the ESI Agreement, and (ii) that it has no obligation to ensure that we receive any specific level of pricing, that we have no contractual right to any change in pricing under the ESI Agreement and that its sole obligation is to negotiate proposed pricing terms in good faith. In the alternative, Express Scripts claims that we have been unjustly enriched by its payment of $4,675 at the time we entered into the ESI Agreement. In March 2017, the District Court granted our motion to dismiss Express Scripts' counterclaims for (i) breach of the implied covenant of good faith and fair dealing, and (ii) unjust enrichment with prejudice. After such ruling, Express Scripts' only remaining claims were for breach of contract and declaratory relief. In August 2021, Express Scripts filed a motion for summary judgment, which we opposed. In March 2022, the District Court granted in part and denied in part Express Scripts' motion for summary judgment. The District Court dismissed our declaratory judgment claim, our breach of contract claim for failure to prove damages and most of our operational breach claims. As a result of the summary judgment decision, the only remaining claims as of the filing of this Quarterly Report on Form 10-Q are (i) our operational breach claim based on Express Scripts' prior authorization processes and (ii) Express Scripts' counterclaim for breach of the market check provision of the ESI Agreement. Express Scripts filed a second motion for summary judgment in June 2022, challenging our remaining operational breach claims, which we opposed, and the District Court denied in March 2023, allowing our operational breach claim to proceed. A trial date has been set for December 2023. We intend to appeal the earlier summary judgment decision at the appropriate time, vigorously pursue our claims and defend against counterclaims, which we believe are without merit; however, the ultimate outcome of this litigation cannot be presently determined.

Medicare Risk Adjustment Litigation

In March 2020, the U.S. Department of Justice ("DOJ") filed a civil lawsuit against Elevance Health, Inc. in the U.S. District Court for the Southern District of New York (the "New York District Court") in a case captioned *United States v. Anthem, Inc*. The DOJ's suit alleges, among other things, that we falsely certified the accuracy of the diagnosis data we submitted to the Centers for Medicare and Medicaid Services ("CMS") for risk-adjustment purposes under Medicare Part C and knowingly failed to delete inaccurate diagnosis codes. The DOJ further alleges that, as a result of these purported acts, we caused CMS to calculate the risk-adjustment payments based on inaccurate diagnosis information, which enabled us to obtain unspecified amounts of payments in Medicare funds in violation of the False Claims Act. The DOJ filed an amended complaint in July 2020, alleging the same causes of action but revising some of its factual allegations. In September 2020, we filed a motion to transfer the lawsuit to the Southern District of Ohio, a motion to dismiss part of the lawsuit, and a motion to strike certain allegations in the amended complaint, all of which the New York District Court denied in October 2022. In November 2022, we filed an answer. In March 2023, discovery commenced, and an initial case management conference was held in April 2023. The Court entered a scheduling order requiring fact discovery to be completed by June 2024 and expert discovery to be complete by February 2025. We intend to continue to vigorously defend this suit, which we believe is without merit; however, the ultimate outcome cannot be presently determined.

Investigations of CareMore and HealthSun

With the assistance of outside counsel, we are conducting investigations of risk-adjustment practices involving data submitted to CMS (unrelated to our retrospective chart review program) at CareMore Health Plans, Inc. ("CareMore"), one of our California subsidiaries, and HealthSun Health Plans, Inc. ("HealthSun"), one of our Florida subsidiaries. Our CareMore investigation has resulted in the termination of CareMore's relationship with one contracted provider in California. Our HealthSun investigation has focused on risk adjustment practices initiated prior to our acquisition of HealthSun in December 2017 that continued after the acquisition. We have voluntarily self-disclosed the existence of both of our investigations to CMS and the Criminal and Civil Divisions of the DOJ. We are cooperating with the ongoing investigations of the Criminal and Civil Divisions of the DOJ related to these risk adjustment practices, and have entered into a tolling agreement with the Civil Division of the DOJ related to its investigation. We have submitted corrected data to CMS related to these investigations. We have also asserted indemnity claims for escrowed funds under the HealthSun purchase agreement for, among other things, breach of healthcare and financial representation provisions, based on the conduct discovered during our investigation. While certain elements of the indemnity claims were resolved in the fourth quarters of 2021 and 2022, litigation in the Delaware Court of Chancery related to the remaining indemnity claims for escrowed funds remains ongoing.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like Health Maintenance Organizations ("HMOs") and health insurers generally, exclude certain healthcare and other services from coverage under our HMO, Preferred Provider Organizations and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable reimbursement of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

Contractual Obligations and Commitments

In March 2020, we entered into an agreement with a vendor for information technology infrastructure and related management and support services through June 2025. The agreement superseded certain prior agreements for such services and includes provisions for additional services not provided under those agreements. Our remaining commitment under this agreement at September 30, 2023 is approximately $554. We will have the ability to terminate the agreement upon the occurrence of certain events, subject to early termination fees.

We formed CarelonRx, to market and offer pharmacy services to our affiliated health plan customers, as well as to external customers outside of the health plans we own, starting in the second quarter of 2019. The comprehensive pharmacy services portfolio includes, but is not limited to, formulary management, pharmacy networks, specialty and home delivery pharmacy services and member services. CarelonRx delegates certain pharmacy services, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement, which is set to terminate on December 31, 2024. With CarelonRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy.

12. Capital Stock

Use of Capital – Dividends and Stock Repurchase Program

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

A summary of our cash dividend activity for the nine months ended September 30, 2023 and 2022 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share		Total
Nine Months Ended September 30, 2023					
January 24, 2023	March 10, 2023	March 24, 2023	$1.48	$	351
April 18, 2023	June 9, 2023	June 23, 2023	$1.48	$	350
July 18, 2023	September 8, 2023	September 22, 2023	$1.48	$	348
Nine Months Ended September 30, 2022					
January 25, 2022	March 10, 2022	March 25, 2022	$1.28	$	309
April 19, 2022	June 10, 2022	June 24, 2022	$1.28	$	309
July 19, 2022	September 9, 2022	September 23, 2022	$1.28	$	306

On October 17, 2023, our Audit Committee declared a fourth quarter 2023 dividend to shareholders of $1.48 per share, payable on December 21, 2023 to shareholders of record at the close of business on December 6, 2023.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On January 24, 2023, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized a $5,000 increase to the common stock repurchase program. No duration has been placed on the common stock repurchase program, and we reserve the right to discontinue the program at any time. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are affected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary, as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

A summary of common stock repurchases for the nine months ended September 30, 2023 and 2022 is as follows:

	Nine Months Ended September 30	
	2023	2022
Shares repurchased	3.8	3.7
Average price per share	$ 462.42	$ 473.36
Aggregate cost	$ 1,748	$ 1,748
Authorization remaining at the end of the period	$ 5,128	$ 2,444

For additional information regarding the use of capital for debt security repurchases, see Note 10, "Debt," included in this Quarterly Report on Form 10-Q and Note 13, "Debt," to our audited consolidated financial statements as of and for the year ended December 31, 2022 included in Exhibit 99.1 to this Quarterly Report on Form 10-Q.

Stock Incentive Plans

A summary of stock option activity for the nine months ended September 30, 2023 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2023	2.8	$ 293.28		
Granted	0.6	468.92		
Exercised	(0.2)	265.25		
Forfeited or expired	(0.1)	399.28		
Outstanding at September 30, 2023	3.1	324.74	6.25	$ 370
Exercisable at September 30, 2023	2.0	266.01	5.07	$ 346

A summary of the status of nonvested restricted stock activity, including restricted stock units and performance units, for the nine months ended September 30, 2023 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2023	1.2	$ 357.21
Granted	0.6	469.30
Vested	(0.6)	301.90
Forfeited	(0.1)	413.59
Nonvested at September 30, 2023	1.1	423.34

During the nine months ended September 30, 2023, we granted approximately 0.2 restricted stock units that are contingent upon us achieving earnings targets over the three-year period from 2023 to 2025. These grants have been included in the activity shown above but will be subject to adjustment at the end of 2025 based on results in the three-year period.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. For a more detailed discussion of our stock incentive plan fair value methodology, see Note 15, "Capital Stock," to our audited consolidated financial statements as of and for the year ended December 31, 2022 included in Exhibit 99.1 to this Quarterly Report on Form 10-Q.

The following weighted-average assumptions were used to estimate the fair values of options granted during the nine months ended September 30, 2023 and 2022:

	Nine Months Ended September 30	
	2023	2022
Risk-free interest rate	3.95 %	1.97 %
Volatility factor	29.00 %	29.00 %
Quarterly dividend yield	0.316 %	0.282 %
Weighted-average expected life (years)	4.40	5.10

The following weighted-average fair values per option or share were determined for the nine months ended September 30, 2023 and 2022:

	Nine Months Ended September 30	
	2023	2022
Options granted during the period	$ 127.08	$ 116.85
Restricted stock awards granted during the period	469.30	453.16

13. Accumulated Other Comprehensive Loss

A reconciliation of the components of accumulated other comprehensive loss at September 30, 2023 and 2022 is as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2023	2022	2023	2022
		(Restated)		(Restated)
Net unrealized investment (losses) gains:				
Beginning of period balance	$ (1,449)	$ (1,489)	$ (1,755)	$ 494
Other comprehensive loss before reclassifications, net of tax benefit (expense) of $145, $220, $119 and $896, respectively	(464)	(719)	(317)	(2,914)
Amounts reclassified from accumulated other comprehensive loss, net of tax expense of $(35), $(21), $(86) and $(75), respectively	112	80	273	284
Other comprehensive loss	(352)	(639)	(44)	(2,630)
Other comprehensive loss (income) attributable to noncontrolling interests, net of tax benefit (expense) of $(1), $(1), $(1) and $(4), respectively	2	3	—	11
End of period balance	(1,799)	(2,125)	(1,799)	(2,125)
Non-credit components of impairments on investments:				
Beginning of period balance	(6)	(2)	(3)	—
Other comprehensive income (loss), net of tax benefit of $(1), $0, $0 and $1, respectively	2	(1)	(1)	(3)
End of period balance	(4)	(3)	(4)	(3)
Net cash flow hedges:				
Beginning of period balance	(214)	(233)	(229)	(239)
Other comprehensive income, net of tax (expense) of $(1), $0, $6 and $(2), respectively	1	2	16	8
End of period balance	(213)	(231)	(213)	(231)
Pension and other postretirement benefits:				
Beginning of period balance	(494)	(413)	(499)	(429)
Other comprehensive income, net of tax expense of $0, $(3), $(2) and $(9), respectively	2	7	7	23
End of period balance	(492)	(406)	(492)	(406)
Future policy benefits:				
Beginning of period balance	12	(2)	13	(19)
Other comprehensive income, net of tax expense of $0, $(2), $0 and $(7), respectively	3	7	2	24
End of period balance	15	5	15	5
Foreign currency translation adjustments:				
Beginning of period balance	(15)	(12)	(17)	(4)
Other comprehensive loss, net of tax benefit of $1, $2, $0 and $4, respectively	(4)	(7)	(2)	(15)
End of period balance	(19)	(19)	(19)	(19)
Total:				
Total beginning of period accumulated other comprehensive loss	(2,166)	(2,151)	(2,490)	(197)
Total other comprehensive loss, net of tax benefit (expense) of $109, $196, $37, and $808, respectively	(348)	(631)	(22)	(2,593)
Total other comprehensive loss attributable to noncontrolling interests, net of tax benefit (expense) of $(1), $(1), $(1) and $(4) respectively	2	3	—	11
Total end of period accumulated other comprehensive loss	$ (2,512)	$ (2,779)	$ (2,512)	$ (2,779)

14. Earnings per Share

The denominator for basic and diluted earnings per share for the three and nine months ended September 30, 2023 and 2022 is as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2023	2022	2023	2022
Denominator for basic earnings per share – weighted-average shares	235.3	239.6	236.4	240.5
Effect of dilutive securities – employee stock options, nonvested restricted stock awards and convertible debentures	1.2	2.6	1.6	2.8
Denominator for diluted earnings per share	236.5	242.2	238.0	243.3

During the three months ended September 30, 2023 and 2022, weighted-average shares related to certain stock options of 0.9 and 0.5 respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive. During the nine months ended September 30, 2023 and 2022, weighted-average shares related to certain stock options of 0.8 and 0.4, respectively, were excluded from each of the denominators for diluted earnings per share because the stock options were anti-dilutive.

During the three and nine months ended September 30, 2023, we issued approximately 0.0 and 0.6 restricted stock units under our stock incentive plans, 0.0 and 0.2 of which vesting is contingent upon us meeting specified annual earnings targets for the three-year period of 2023 through 2025. During the three and nine months ended months ended September 30, 2022, we issued approximately 0.0 and 0.6 restricted stock units under our stock incentive plans, 0.0 and 0.2 of which vesting is contingent upon us meeting specified annual earnings targets for the three-year period of 2022 through 2024. The contingent restricted stock units have been excluded from the denominators for diluted earnings per share and will be included only if and when the contingency is met.

15. Segment Information

As discussed in Note 1 “Organization”, we have changed our reportable segment presentation and its composition to reflect how we began managing our operations and monitoring performance, aligning strategies and allocating resources beginning on January 1, 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. In 2022, we managed and presented our operations through the following four reportable segments: Commercial & Specialty Business, Government Business, CarelonRx and Other. Previously reported information throughout this Quarterly Report on Form 10-Q has been reclassified to conform to the new presentation.

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 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 services such as formulary management, pharmacy networks, specialty and home delivery pharmacy services and member services.

Our Carelon Services segment is focused on lowering the cost and improving the quality of healthcare by enabling and creating new care delivery and payment models, with a special emphasis on serving those with complex and chronic conditions. Carelon Services offers a broad array of healthcare-related services and capabilities to internal and external customers including integrated care delivery, behavioral health, palliative care, utilization management, payment integrity services and subrogation services, as well as health and wellness programs.

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.

We define operating revenues to include premium income, product revenue and service fees. Operating revenues are derived from premiums and fees received, primarily from the sale and administration of health benefits and pharmacy products and services. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and operating expense.

Affiliated revenues represent revenues or costs for services provided to our subsidiaries by CarelonRx and Carelon Services, in addition to certain back-office services provided by our international businesses, which are recorded at cost or management's estimate of fair market value. These affiliated revenues are eliminated in consolidation.

Financial data by reportable segment for the three months ended September 30, 2023 and 2022 is as follows:

		Carelon					
	Health Benefits	CarelonRx	Carelon Services	Total	Corporate & Other	Eliminations	Total
Three Months Ended September 30, 2023							
Premiums	$ 34,934	$ —	$ 422	$ 422	$ —	$ (97)	$ 35,259
Product revenue	—	5,177	—	5,177	—	—	5,177
Service fees	1,810	4	196	200	34	—	2,044
Operating revenue - unaffiliated	36,744	5,181	618	5,799	34	(97)	42,480
Operating revenue - affiliated	—	3,337	2,756	6,093	208	(6,301)	—
Operating revenue - total	$ 36,744	$ 8,518	$ 3,374	$ 11,892	$ 242	$ (6,398)	$ 42,480
Operating gain (loss)	$ 1,847	$ 477	$ 173	$ 650	$ (741)	$ —	$ 1,756
Three Months Ended September 30, 2022							
Premiums	$ 33,376	$ —	$ 412	$ 412	$ —	$ (66)	$ 33,722
Product revenue	—	3,972	—	3,972	—	—	3,972
Service fees	1,689	—	224	224	18	—	1,931
Operating revenue - unaffiliated	35,065	3,972	636	4,608	18	(66)	39,625
Operating revenue - affiliated	—	3,277	2,518	5,795	193	(5,988)	—
Operating revenue - total	$ 35,065	$ 7,249	$ 3,154	$ 10,403	$ 211	$ (6,054)	$ 39,625
Operating gain (loss) (restated)	$ 1,634	$ 516	$ 125	$ 641	$ (24)	$ —	$ 2,251

Financial data by reportable segment for the nine months ended September 30, 2023 and 2022 is as follows:

	Health Benefits	Carelon			Corporate & Other	Eliminations	Total
		CarelonRx	Carelon Services	Total			
Nine Months Ended September 30, 2023							
Premiums	$ 106,701	$ —	$ 1,261	$ 1,261	$ —	$ (246)	$ 107,716
Product revenue	—	14,058	—	14,058	—	—	14,058
Service fees	5,323	4	604	608	50	—	5,981
Operating revenue - unaffiliated	112,024	14,062	1,865	15,927	50	(246)	127,755
Operating revenue - affiliated	—	10,946	8,262	19,208	730	(19,938)	—
Operating revenue - total	$ 112,024	$ 25,008	$ 10,127	$ 35,135	$ 780	$ (20,184)	$ 127,755
Operating gain (loss)	$ 6,154	$ 1,485	$ 518	$ 2,003	(942)	—	7,215
Nine Months Ended September 30, 2022							
Premiums	$ 98,626	$ —	$ 1,105	$ 1,105	$ —	$ (148)	$ 99,583
Product revenue	—	10,841	—	10,841	—	—	10,841
Service fees	4,862	—	670	670	37	—	5,569
Operating revenue - unaffiliated	103,488	10,841	1,775	12,616	37	(148)	115,993
Operating revenue - affiliated	—	10,162	7,310	17,472	762	(18,234)	—
Operating revenue - total	$ 103,488	$ 21,003	$ 9,085	$ 30,088	$ 799	$ (18,382)	$ 115,993
Operating gain (loss) (restated)	$ 5,266	$ 1,393	$ 438	$ 1,831	$ (73)	$ —	$ 7,024

For segment reporting, we present all capitated risk arrangements on a gross basis; therefore, eliminations also include adjustments for unaffiliated capitated risk arrangements that are recognized on a net basis under GAAP, as well as affiliated eliminations.

A reconciliation of reportable segments' operating revenue to the amounts of total revenues included in our consolidated statements of income for the three and nine months ended September 30, 2023 and 2022 is as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2023	2022	2023	2022
Reportable segments' operating revenue	$ 42,480	$ 39,625	$ 127,755	$ 115,993
Net investment income	493	371	1,296	1,112
Net losses on financial instruments	(124)	(57)	(358)	(439)
Total revenues	$ 42,849	$ 39,939	$ 128,693	$ 116,666

A reconciliation of income before income tax expense to reportable segments' operating gain included in our consolidated statements of income for the three and nine months ended September 30, 2023 and 2022 is as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2023	2022	2023	2022
		(Restated)		(Restated)
Income before income tax expense	$ 1,654	$ 2,127	$ 6,714	$ 6,555
Net investment income	(493)	(371)	(1,296)	(1,112)
Net losses on financial instruments	124	57	358	439
Interest expense	259	213	771	622
Amortization of other intangible assets	212	225	668	520
Reportable segments' operating gain	$ 1,756	$ 2,251	$ 7,215	$ 7,024

16. Leases

We lease office space and certain computer and related equipment using noncancellable operating leases. Our leases have remaining lease terms of 1 year to 12 years.

The information related to our leases is as follows:

	Balance Sheet Location	September 30, 2023	December 31, 2022
Operating Leases			
Right-of-use assets	Other noncurrent assets	$ 573	$ 604
Lease liabilities, current	Other current liabilities	172	181
Lease liabilities, noncurrent	Other noncurrent liabilities	695	751

	Three Months Ended September 30		Nine Months Ended September 30	
	2023	2022	2023	2022
Lease Expense				
Operating lease expense	$ 69	$ 35	$ 126	$ 100
Short-term and variable lease expense	—	11	28	35
Sublease income	(1)	(1)	(4)	(3)
Total lease expense	$ 68	$ 45	$ 150	$ 132
Other information				
Operating cash paid for amounts included in the measurement of lease liabilities, operating leases	$ 53	$ 53	$ 156	$ 158
Right-of-use assets obtained in exchange for new lease liabilities, operating leases	$ —	$ 23	$ 47	$ 62

As of September 30, 2023 and December 31, 2022, the weighted average remaining lease term of our operating leases was 7 years for each period. The lease liabilities reflect a weighted average discount rate of 3.53% at September 30, 2023 and 2.98% at December 31, 2022. Our activities as disclosed in Note 4, "Business Optimization Initiatives", include reducing our office space footprint. As a result, during the quarter ended September 30, 2023 we recorded impairment charges of $23 for abandonment of right-of-use assets which are included in the operating lease expense shown above.

Future lease payments for noncancellable operating leases with initial or remaining terms of one year or more are as follows:

2023 (excluding the nine months ended September 30, 2023)	$	54
2024		195
2025		163
2026		130
2027		97
Thereafter		335
Total future minimum payments		974
Less imputed interest		107
Total lease liabilities	$	867

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

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

This Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") should be read in conjunction with the accompanying consolidated financial statements and notes, as well as our consolidated financial statements and notes as of and for the year ended December 31, 2022 and the MD&A included in Exhibit 99.1 to this Quarterly Report on Form 10-Q. References to the terms "we," "our," "us," or "Elevance Health" used throughout this MD&A refer to Elevance Health, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia and Puerto Rico, unless the context otherwise requires.

We are filing Exhibit 99.1 to this Quarterly Report on Form 10-Q to recast certain prior years' financial information and related disclosures included in Part I, Item 1, "Business," Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Part II, Item 8, "Financial Statements and Supplementary Data" of our 2022 Annual Report on Form 10-K to reflect changes to our reportable segments beginning in the first quarter of 2023, as well as the impact of the adoption of a new accounting standard related to the accounting for long-duration insurance contracts, which we adopted on January 1, 2023, using a modified retrospective transition method as of January 1, 2021. The recast financial information and related disclosures set forth in Exhibit 99.1 to this Quarterly Report on Form 10-Q present such financial information and related disclosures in these items as they would have appeared had we changed our reportable segments and adopted the new accounting standard prior to January 1, 2023 and do not reflect events or developments that may have occurred subsequent to the filing of our 2022 Annual Report on Form 10-K.

Results of operations, cost of care trends, investment yields and other measures for the three and nine months ended September 30, 2023 are not necessarily indicative of the results and trends that may be expected for the full year ending December 31, 2023, or any other period.

Overview

Elevance Health is a health company with the purpose of improving the health of humanity. We are one of the largest health insurers in the United States in terms of medical membership, serving over 47 million medical members through our affiliated health plans as of September 30, 2023. We are an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent health benefit plans, and serve members as the Blue Cross or Blue Cross and Blue Shield licensee in 14 states. 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 and other healthcare-related services.

As we announced in 2022, over the next several years 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; and
- 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 brands 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 our 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). In 2022, we managed and presented our operations through the following four reportable segments: Commercial & Specialty Business, Government Business, CarelonRx and Other. Previously reported information in this Quarterly Report on Form 10-Q has been reclassified to conform to the new presentation. For additional information, see Note 15, "Segment Information," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

For additional information about our organization, see Part I, Item 1, "Business" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations," included in Exhibit 99.1 to this Quarterly Report on Form 10-Q.

Business Trends

We made the decision to expand our participation in the Individual state- or federally-facilitated marketplaces (the "Public Exchange") for 2023. As a result, for 2023, we are offering Individual Public Exchange products in 138 of the 143 rating regions in which we operate, in comparison to 122 of 143 rating regions in 2022. As described in "*Regulatory Trends and Uncertainties*" below, we 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. Changes to our business environment are likely to continue as elected officials at the national 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. In addition, growth in our government-sponsored business exposes us to increased regulatory oversight.

Our CarelonRx subsidiary markets and offers pharmacy services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. Our comprehensive pharmacy services portfolio includes features such as formulary management, pharmacy networks, specialty and home delivery pharmacy services and member services. CarelonRx delegates certain pharmacy services, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement, which is set to terminate on December 31, 2024. With CarelonRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy.

Pricing Trends: We strive to price our health benefit products consistent with anticipated underlying medical cost trends. We frequently make adjustments to respond to legislative and regulatory changes as well as pricing and other actions taken by existing competitors and new market entrants. Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. Product pricing remains competitive.

Medical Cost Trends: Our medical cost trends are primarily driven by increases in the utilization of services across all provider types and the unit cost increases of these services. We work to mitigate these trends through various medical management programs such as care and condition management, program integrity and specialty pharmacy management and utilization management, as well as benefit design changes. There are many drivers of medical cost trends that can cause variance from our estimates, such as changes in the level and mix of services utilized, regulatory changes, aging of the population, health status and other demographic characteristics of our members, epidemics, pandemics, advances in medical technology, new high-cost prescription drugs, provider contracting inflation, labor costs and healthcare provider or member fraud.

For additional discussion regarding business trends, see Part I, Item 1, "Business" included in Exhibit 99.1 to this Quarterly Report on Form 10-Q.

Regulatory Trends and Uncertainties

Under the Consolidated Appropriations Act of 2023 (the "2023 Appropriations Act"), Congress decoupled Medicaid eligibility redeterminations 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. As redeterminations have resumed, we have experienced a decline in our Medicaid membership. Over time, we expect growth in our commercial plans, including through the Public Exchanges, 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. Some states such as California have extended their COVID-19 related policies beyond the PHE.

The Inflation Reduction Act of 2022, 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 Centers for Medicare and Medicaid Services ("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 until 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 "Appropriations Act") has impacted 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 Appropriations Act applicable to us have varying effective dates, some of which were effective in December 2021 and others that were extended into 2023 since the enactment of the Appropriations Act.

The health plan price transparency regulations issued by the U.S. Departments of Health and Human Services, Labor and Treasury required us in 2022 to begin disclosing 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 are now 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. In 2024, this requirement will expand to all items and services.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the "ACA"), continues to impact our business and results of operations, including pricing, minimum medical loss ratios 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.

For additional discussion regarding regulatory trends and uncertainties and risk factors, see Part I, Item 1, "Business – Regulation" and the "Regulatory Trends and Uncertainties" section of Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Exhibit 99.1 to this Quarterly Report on Form 10-Q, and Part I, Item 1A, "Risk Factors" of our 2022 Annual Report on Form 10-K.

Other Significant Items

Business and Operational Matters

During the third quarter of 2023, based on a strategic review of our operations, assets and investments, management implemented the "2023-2024 Business Efficiency Program" to refine the focus of our investments, and optimize our physical footprint. The 2023-2024 Business Efficiency Program includes the write-off of certain information technology assets and contract exit costs, a reduction in staff including the relocation of certain job functions, and the impairment of assets associated with the closure or partial closure of data centers and offices. The 2023-2024 Business Efficiency Program is expected to be substantially complete by the end of the third quarter of 2024. For additional information, see Note 4, "Business Optimization Initiatives" and Note 16, "Leases," of the Notes to Consolidated Financial Statements included in Part 1, Item 1 of this Quarterly Report on Form 10-Q.

Pursuant to CMS's Medicare Advantage Star ratings system, CMS annually awards between 1.0 and 5.0 Stars to Medicare Advantage plans based on performance in several categories. Plans must have a Star rating of 4.0 or higher to qualify for bonus payments. CMS released the Company's 2024 Star ratings in October 2023. The Company's 2024 Star ratings will be used to determine the Company's Medicare Advantage plans' Star quality bonus payments in 2025. Based on 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 the Company's membership at September 1, 2022. The change in our 2024 Star ratings is not projected to impact our Star quality bonus payments and plan level rebates until 2025. We expect a reduction to our 2025 operating revenue of approximately $500, net of offsets from contracting provisions. Further, we expect to mitigate the financial impact to our 2025 operating gain and net income per share through various strategies such as contract diversification, operating expense efficiencies, capital deployment alternatives and network enhancements.

On March 28, 2023, we announced our entrance into an agreement to sell our life and disability businesses to StanCorp Financial Group, Inc. ("The Standard"), a provider of financial protection products and services for employers and individuals. Upon closing, we and The Standard will enter into a product distribution partnership. The divestiture is expected to close in the first half of 2024 and is subject to standard closing conditions and customary approvals.

On January 23, 2023, we announced our entrance into an agreement to acquire Louisiana Health Service & Indemnity Company, d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), an independent licensee of the BCBSA that provides healthcare plans to the Individual, Employer Group, Medicaid and Medicare markets, primarily in the State of Louisiana. This acquisition aligns with our mission to become a lifetime, trusted health partner as we bring our innovative whole-health solutions to BCBSLA's members. The acquisition is expected to close in the first half of 2024 and is subject to standard closing conditions and customary approvals.

On February 15, 2023, we completed our acquisition of BioPlus Parent, LLC and subsidiaries ("BioPlus") from CarepathRx Aggregator, LLC. Prior to the acquisition, BioPlus was one of the largest independent specialty pharmacy organizations in the United States. BioPlus, which operates as part of CarelonRx, seeks to connect payors and providers of specialty pharmaceuticals to meet the medication therapy needs of patients with complex medical conditions. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve.

On May 5, 2022, we completed our acquisition of Integra Managed Care ("Integra"). Integra is a managed long-term care plan that serves New York state Medicaid members, enabling adults with long-term care needs and disabilities to live safely and independently in their own homes.

For additional information, see Note 3, "Business Acquisitions and Divestitures," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

Litigation Matters

In the consolidated multi-district proceeding in the United States District Court for the Northern District of Alabama (the "Court") captioned *In re Blue Cross Blue Shield Antitrust Litigation* ("BCBSA Litigation"), the BCBSA and Blue Cross and/or Blue Shield licensees, including us (the "Blue plans") previously approved a settlement agreement and release with the

plaintiffs representing a putative nationwide class of health plan subscribers (the "Subscriber Settlement Agreement"), which agreement required the Court's approval to become effective. Generally, the lawsuits in the BCBSA Litigation challenge elements of the licensing agreements between the BCBSA and the independently owned and operated Blue plans. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers. The Subscriber Settlement Agreement applies only to the subscriber class. The defendants continue to contest the consolidated cases brought by the provider plaintiffs.

In August 2022, the Court issued a final order approving the Subscriber Settlement Agreement (the "Final Approval Order"). In compliance with the Subscriber Settlement Agreement, the Company paid $506 into an escrow account in September 2022, for an aggregate and full settlement payment by the Company of $596, which amount was accrued in 2020. Four notices of appeal of the Final Approval Order were filed prior to the September 2022 appeal deadline. Those appeals were heard by a panel of the United States Court of Appeals for the Eleventh Circuit in September 2023. In the event all appellate rights are exhausted in a manner that affirms the Court's Final Approval Order, the defendants' payment and non-monetary obligations under the Subscriber Settlement Agreement will become effective and the funds held in escrow will be distributed in accordance with the Subscriber Settlement Agreement. For additional information regarding the BCBSA Litigation, see Note 11, "Commitments and Contingencies – *Litigation and Regulatory Proceedings – Blue Cross Blue Shield Antitrust Litigation*," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

Selected Operating Performance

For the twelve months ended September 30, 2023, total medical membership increased slightly. This was primarily driven by increases in our BlueCard business, as well as growth in our Individual Public Exchange and Medicare Advantage products. These increases were partially offset by attrition in our Medicaid business due to the resumption of eligibility redeterminations and reduced membership due to a new entrant into one of our state Medicaid programs, as well as lapses exceeding sales in our Employer Group risk-based business.

Operating revenue for the three months ended September 30, 2023 was $42,480, an increase of $2,855, or 7.2%, from the three months ended September 30, 2022. The increase was primarily a result of higher premium revenues due to premium rate increases in our Health Benefits business to more accurately reflect the cost of care. The increase was further attributable to growth in our CarelonRx pharmacy product revenue driven by growth in external pharmacy members and the acquisition of BioPlus in the first quarter of 2023.

Operating revenue for the nine months ended September 30, 2023 was $127,755, an increase of $11,762, or 10.1%, from the nine months ended September 30, 2022. This increase in operating revenue was primarily a result of higher premium revenues due to premium rate increases in our Health Benefits business to more accurately reflect the cost of care and membership growth in our Medicaid business in the first half of 2023, as well as in our Medicare Advantage business. The increase was further attributable to growth in our CarelonRx pharmacy product revenue driven by growth in external pharmacy members and the acquisition of BioPlus in the first quarter of 2023.

Net income for the three months ended September 30, 2023 was $1,300, a decrease of $298, or 18.6%, from the three months ended September 30, 2022. This decline was primarily due to business optimization charges recorded during the third quarter of 2023 and increased net losses on financial instruments, partially offset by operating gain increases in our Health Benefits and Carelon Services segments, higher net investment income and lower income taxes.

Net income for the nine months ended September 30, 2023 was $5,160, an increase of $149, or 3.0%, from the nine months ended September 30, 2022. This increase in net income was primarily due to operating gain increases in our Health Benefits, CarelonRx and Carelon Services segments and increased net investment income. These increases were offset by business optimization charges recorded in the third quarter of 2023 and higher interest expense and amortization of other intangible assets.

Our fully-diluted shareholders' earnings per share ("EPS") was $5.45 for the three months ended September 30, 2023, which represented a 17.7% decrease from EPS of $6.62 for the three months ended September 30, 2022. This decrease in EPS for the three months ending September 30, 2023 resulted primarily from lower shareholders' net income, partially offset by the impact of fewer diluted shares outstanding.

Our fully-diluted EPS was $21.56 for the nine months ended September 30, 2023, which represented a 4.3% increase from fully-diluted EPS of $20.67 for the nine months ended September 30, 2022. This increase in EPS for the nine months ending September 30, 2023 resulted primarily from fewer diluted shares outstanding, as well as increased shareholders' net income.

Operating cash flow for the nine months ended September 30, 2023 and 2022 was $11,032 and $9,917, respectively. The increase was primarily due to higher net income in 2023, when excluding the non-cash impact of business optimization charges recognized in the third quarter of 2023, as well as the non-recurrence of the Subscriber Settlement Agreement payment made in September 2022.

Membership and Other Metrics

The following table presents our medical membership by customer type as of September 30, 2023 and 2022. Also included below are other membership by product and other metrics. The membership data and other metrics presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period. The CarelonRx Quarterly Adjusted Scripts metric represents adjusted script volume based on the number of days a prescription covers. On an adjusted basis, one 90-day script counts the same as three 30-day scripts. The Carelon Services Consumers Served metric represents the number of consumers receiving one or more healthcare-related services from Carelon Services who are members of our affiliated health plans as well as those who are members of non-affiliated health plans. For a more detailed description of our medical membership, see the "Membership" section of Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Exhibit 99.1 to this Quarterly Report on Form 10-Q.

	September 30			
	2023	2022	Change	% Change
Medical Membership *(in thousands)*				
Individual	999	800	199	24.9 %
Employer Group Risk-Based	3,754	3,988	(234)	(5.9)%
Commercial Risk-Based	4,753	4,788	(35)	(0.7)%
BlueCard®	6,756	6,453	303	4.7 %
Employer Group Fee-Based	20,166	20,184	(18)	(0.1)%
Commercial Fee-Based	26,922	26,637	285	1.1 %
Medicare Advantage	2,064	1,969	95	4.8 %
Medicare Supplement	928	945	(17)	(1.8)%
Total Medicare	2,992	2,914	78	2.7 %
Medicaid	11,018	11,319	(301)	(2.7)%
Federal Employees Health Benefits ("FEHB")	1,640	1,625	15	0.9 %
Total Medical Membership	47,325	47,283	42	0.1 %
Other Membership *(in thousands)*				
Life and Disability Members	4,611	4,796	(185)	(3.9)%
Dental Members	6,775	6,655	120	1.8 %
Dental Administration Members	1,708	1,577	131	8.3 %
Vision Members	9,861	9,628	233	2.4 %
Medicare Part D Standalone Members	261	274	(13)	(4.7)%
Other Metrics *(in millions)*				
CarelonRx Quarterly Adjusted Scripts	77.3	76.9	0.4	0.5 %
Carelon Services Consumers Served	104.8	105.3	(0.5)	(0.5)%

Medical Membership

Medical membership increased slightly during the twelve months ended September 30, 2023. This was primarily driven by increases in our BlueCard business, as well as growth in our Individual Public Exchange and Medicare Advantage products. These increases were partially offset by attrition in our Medicaid business due to the resumption of eligibility redeterminations and reduced membership due to a new entrant into one of our state Medicaid programs, as well as lapses exceeding sales in our Employer Group risk-based business.

Other Membership

Our other membership can be impacted by changes in our medical membership, as our medical members often purchase our other products that are ancillary to our health business. Life and disability membership decreased primarily due to lapses associated with our Employer Group risk-based accounts. Dental membership increased primarily due to increases in our FEHB program. Dental administration membership increased primarily due to favorable in-group change with other BCBSA plans associated with the FEHB program. Vision membership increased due to sales exceeding lapses in our Employer Group risk based accounts and increases associated with our Medicare Advantage plans.

Consolidated Results of Operations

Our consolidated summarized results of operations and other financial information for the three and nine months ended September 30, 2023 and 2022 are as follows:

	Three Months Ended September 30		Nine Months Ended September 30		Change			
					Three Months Ended September 30		Nine Months Ended September 30	
					2023 vs. 2022		2023 vs. 2022	
	2023	2022	2023	2022	$	%	$	%
		(Restated)		(Restated)				
Total operating revenue	$ 42,480	$ 39,625	$ 127,755	$ 115,993	$ 2,855	7.2 %	$ 11,762	10.1 %
Net investment income	493	371	1,296	1,112	122	32.9 %	184	16.5 %
Net losses on financial instruments	(124)	(57)	(358)	(439)	(67)	117.5 %	81	(18.5)%
Total revenues	42,849	39,939	128,693	116,666	2,910	7.3 %	12,027	10.3 %
Benefit expense	30,606	29,421	92,996	86,447	1,185	4.0 %	6,549	7.6 %
Cost of products sold	4,648	3,437	12,456	9,389	1,211	35.2 %	3,067	32.7 %
Operating expense	5,470	4,516	15,088	13,133	954	21.1 %	1,955	14.9 %
Other expense[1]	471	438	1,439	1,142	33	7.5 %	297	26.0 %
Total expenses	41,195	37,812	121,979	110,111	3,383	8.9 %	11,868	10.8 %
Income before income tax expense	1,654	2,127	6,714	6,555	(473)	(22.2)%	159	2.4 %
Income tax expense	354	529	1,554	1,544	(175)	(33.1)%	10	0.6 %
Net income	$ 1,300	$ 1,598	$ 5,160	$ 5,011	$ (298)	(18.6)%	$ 149	3.0 %
Net (income) loss attributable to noncontrolling interests	(11)	5	(29)	18	(16)	NM	(47)	NM
Shareholders' net income	$ 1,289	$ 1,603	$ 5,131	$ 5,029	$ (314)	(19.6)%	$ 102	2.0 %
Average diluted shares outstanding	236.5	242.2	238.0	243.3	(5.7)	(2.4)%	(5.3)	(2.2)%
Diluted shareholders' net income per share	$ 5.45	$ 6.62	$ 21.56	$ 20.67	$ (1.17)	(17.7)%	$ 0.89	4.3 %
Effective tax rate	21.4 %	24.9 %	23.1 %	23.6 %		(350) bp[3]		(50) bp[3]
Benefit expense ratio[2]	86.8 %	87.2 %	86.3 %	86.8 %		(40) bp[3]		(50) bp[3]
Operating expense ratio[4]	12.9 %	11.4 %	11.8 %	11.3 %		150 bp[3]		50 bp[3]
Income before income tax expense as a percentage of total revenues	3.9 %	5.3 %	5.2 %	5.6 %		(140) bp[3]		(40) bp[3]
Shareholders' net income as a percentage of total revenues	3.0 %	4.0 %	4.0 %	4.3 %		(100) bp[3]		(30) bp[3]

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

NM Not meaningful.

1 Includes interest expense and amortization of other intangible assets.

2 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the three months ended September 30, 2023 and 2022 were $35,259 and $33,722, respectively. Premiums for the nine months ended September 30, 2023 and 2022 were $107,716 and $99,583, respectively.

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

4 Operating expense ratio represents operating expense as a percentage of total operating revenue.

Three Months Ended September 30, 2023 Compared to the Three Months Ended September 30, 2022

Total operating revenue increased primarily as a result of higher premium revenues due to premium rate increases in our Health Benefits business to more accurately reflect the cost of care. The increase was further attributable to growth in our CarelonRx pharmacy product revenue driven by growth in external pharmacy members and the acquisition of BioPlus in the first quarter of 2023.

Net investment income increased primarily due to higher income from fixed maturity securities, partially offset by reduced income from alternative investments and equity securities.

Net losses on financial instruments increased primarily due to increased losses on the sale of fixed maturity securities and other invested assets.

Benefit expense increased primarily due to medical cost trends.

Our benefit expense ratio decreased, driven by premium rate increases to more accurately reflect cost of care, partially offset by the impact of the realignment of certain year-to-date quality improvement costs from benefit expense to operating expense that occurred in the third quarter of 2022 and did not recur in the third quarter of 2023.

Cost of products sold reflects the cost of pharmaceuticals dispensed by CarelonRx for our unaffiliated customers. Cost of products sold increased as the corresponding pharmacy product revenues increased.

Operating expense increased primarily due to the business optimization charges recorded in the third quarter of 2023, including internally developed software impairment and severance costs. There were no business optimization charges recorded in the third quarter of 2022. These increases were partially offset by the realignment of certain year-to-date quality improvement costs from benefit expense to operating expense that occurred in the third quarter of 2022 and did not recur in the third quarter of 2023.

Our operating expense ratio increased primarily due to the business optimization charges recognized in the third quarter of 2023, partially offset by the favorable impact of operating revenue growth and the impact of the realignment of certain year-to-date quality improvement costs from benefit expense that occurred in the third quarter of 2022 and did not recur in the third quarter of 2023.

Other expense increased primarily due to an increase in interest expense, partially offset by a decline in amortization of other intangible assets.

Our effective income tax rate decreased in 2023 primarily due to the tax impact of expected geographic changes in our mix of 2023 earnings.

Our shareholders' net income as a percentage of total revenues declined in 2023 as compared to 2022 as a result of all factors discussed above.

Nine Months Ended September 30, 2023 Compared to the Nine Months Ended September 30, 2022

Total operating revenue increased primarily as a result of higher premium revenues due to premium rate increases in our Health Benefits business to more accurately reflect the cost of care and membership growth in our Medicaid business in the first half of 2023, as well as in our Medicare Advantage business. The increase was further attributable to growth in our

CarelonRx pharmacy product revenue driven by growth in external pharmacy members and the acquisition of BioPlus in the first quarter of 2023.

Net investment income increased primarily due to higher income from fixed maturity securities, partially offset by reduced income from alternative investments and equity securities.

Net losses on financial instruments decreased primarily due to increased mark-to-market gains on equity securities still held at the period end date, partially offset by reduced net gains on other invested assets and increased net losses on fixed maturity securities.

Benefit expense increased primarily due to medical cost trends as well as healthcare costs associated with membership growth.

Our benefit expense ratio decreased, primarily driven by premium rate increases in our Health Benefits segment to more accurately reflect the cost of care.

Cost of products sold reflects the cost of pharmaceuticals dispensed by CarelonRx for our unaffiliated customers. Cost of products sold increased as the corresponding pharmacy product revenues increased.

Operating expense increased primarily due to the business optimization charges recorded in the third quarter of 2023 and increased costs to support growth. There were no business optimization charges recorded in 2022.

Our operating expense ratio increased primarily due to the business optimization charges recorded in the third quarter of 2023 and increased costs to support growth, partially offset by the favorable impact of operating revenue growth.

Other expense increased primarily due to an increase in interest expense and additional amortization of other intangible assets.

Our effective income tax rate decreased in 2023 primarily due to the tax impact of expected geographic changes in our mix of 2023 earnings.

Our shareholders' net income as a percentage of total revenues decreased in 2023 as compared to 2022 as a result of all factors discussed above.

Reportable Segments Results of Operations

Our results of operations discussed throughout this MD&A are determined in accordance with U.S. generally accepted accounting principles ("GAAP"). We also calculate operating gain and operating margin to further aid investors in understanding and analyzing our core operating results and comparing them among periods. We define operating revenue as premium income, product revenue and service fees. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and operating expense. It does not include net investment income, net losses on financial instruments, interest expense, amortization of other intangible assets or income taxes, as these items are managed in our corporate shared service environment and are not the responsibility of operating segment management. Operating margin is calculated as operating gain divided by operating revenue. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating periods and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, shareholders' net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For a reconciliation of reportable segments' operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of income before income tax expense to reportable segments' operating gain, see Note 15, "Segment Information," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

As discussed in Note 1 "Organization," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q, we changed our reportable segment presentation and its composition to reflect how we began managing our operations and monitoring performance, aligning strategies and allocating resources beginning on January 1, 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). In 2022, we managed and presented our operations through the following four reportable segments: Commercial & Specialty Business, Government Business, CarelonRx and Other. Previously reported information in this Quarterly Report on Form 10-Q has been reclassified to conform to the new presentation. For additional information, see Note 15, "Segment Information," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

The following table presents a summary of the reportable segment financial information for the three and nine months ended September 30, 2023 and 2022:

	Three Months Ended September 30		Nine Months Ended September 30		Change			
					Three Months Ended September 30		Nine Months Ended September 30	
					2023 vs. 2022		2023 vs. 2022	
	2023	2022	2023	2022	$	%	$	%
Operating Revenue								
Health Benefits	$ 36,744	$ 35,065	$ 112,024	$ 103,488	$ 1,679	4.8 %	$ 8,536	8.2 %
CarelonRx	8,518	7,249	25,008	21,003	1,269	17.5 %	4,005	19.1 %
Carelon Services	3,374	3,154	10,127	9,085	220	7.0 %	1,042	11.5 %
Corporate & Other	242	211	780	799	31	14.7 %	(19)	(2.4)%
Eliminations	(6,398)	(6,054)	(20,184)	(18,382)	(344)	5.7 %	(1,802)	9.8 %
Total operating revenue	$ 42,480	$ 39,625	$ 127,755	$ 115,993	$ 2,855	7.2 %	$ 11,762	10.1 %
Operating Gain (Loss)		(Restated)		(Restated)				
Health Benefits	$ 1,847	$ 1,634	$ 6,154	$ 5,266	$ 213	13.0 %	$ 888	16.9 %
CarelonRx	477	516	1,485	1,393	(39)	(7.6)%	92	6.6 %
Carelon Services	173	125	518	438	48	38.4 %	80	18.3 %
Corporate & Other	(741)	(24)	(942)	(73)	(717)	NM	(869)	NM
Operating Margin								
Health Benefits	5.0 %	4.7 %	5.5 %	5.1 %		30 bp		40 bp
CarelonRx	5.6 %	7.1 %	5.9 %	6.6 %		(150) bp		(70) bp
Carelon Services	5.1 %	4.0 %	5.1 %	4.8 %		110 bp		30 bp

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

Three Months Ended September 30, 2023 Compared to the Three Months Ended September 30, 2022

Health Benefits

Operating revenue and operating gain increased primarily as a result of higher premium revenues due to premium rate increases to more accurately reflect the cost of care.

CarelonRx

Operating revenue increased primarily as a result of growth in external pharmacy members and the acquisition of BioPlus in the first quarter of 2023, partially offset by the impact of a favorable out-of-period adjustment in the third quarter of 2022 that did not recur in the third quarter of 2023.

Operating gain decreased primarily due to the impact of a favorable out-of-period adjustment in the third quarter of 2022 that did not recur in the third quarter of 2023, partially offset by the acquisition of BioPlus in the first quarter of 2023 and growth in external pharmacy members.

Carelon Services

Operating revenue increased primarily due to the continued expansion of our post-acute care services business performed for our Medicare business and behavioral health services performed for our Medicaid business.

The increase in operating gain was primarily driven by the continued expansion of our post-acute care services business and improved performance in our behavioral health business.

Corporate & Other

Operating revenue increased primarily due to higher affiliated revenue in our international operations.

Operating loss increased primarily due to the business optimization charges recorded in the third quarter of 2023.

Nine Months Ended September 30, 2023 Compared to the Nine Months Ended September 30, 2022

Health Benefits

Operating revenue increased primarily due to higher premium revenues due to premium rate increases to more accurately reflect the cost of care and membership growth in our Medicaid business in the first half of 2023, as well as in our Medicare Advantage business.

Operating gain increased primarily due to premium rate increases to more accurately reflect the cost of care and membership growth in our Medicaid business, partially offset by a charge associated with a court ruling impacting health plans in a certain state related to prior years' COVID-19 costs.

CarelonRx

Operating revenue increased primarily as a result of growth in external pharmacy members and the acquisition of BioPlus in the first quarter of 2023.

Operating gain increased primarily due to growth in external pharmacy members and the acquisition of BioPlus in the first quarter of 2023, partially offset by the impact of a favorable out-of-period adjustment in the third quarter of 2022 that did not recur in the third quarter of 2023.

Carelon Services

Operating revenue increased primarily due to the continued expansion of our post-acute care services business performed for our Medicare business and behavioral health services performed for our Medicaid business.

The increase in operating gain was primarily driven by the continued expansion of our post-acute care services and improved performance in our medical management businesses, partially offset by medical cost trends.

Corporate & Other

Operating revenue decreased primarily due to lower affiliated revenues in our international operations.

Operating loss increased primarily due to an increase in corporate expenses, including primarily for the business optimization charges recorded in the third quarter of 2023.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits. Our accounting policies related to these items are discussed in Exhibit 99.1 to this Quarterly Report on Form 10-Q in Note 2, "Basis of Presentation and Significant Accounting

Policies," to our audited consolidated financial statements as of and for the year ended December 31, 2022, as well as in the "Critical Accounting Policies and Estimates" section of Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations." As of September 30, 2023, our critical accounting policies and estimates have not changed from those described in Exhibit 99.1 to this Quarterly Report on Form 10-Q.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. Our accounting policies related to medical claims payable are discussed in the references cited above. As of September 30, 2023, our critical accounting policies and estimates related to medical claims payable have not changed from those described in Exhibit 99.1 to this Quarterly Report on Form 10-Q. For a reconciliation of the beginning and ending balance for medical claims payable for the nine months ended September 30, 2023 and 2022, see Note 9, "Medical Claims Payable," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the nine months ended September 30, 2023 and 2022, which are the trend and completion factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

	Favorable Developments by Changes in Key Assumptions	
	Nine Months Ended September 30	
	2023	2022
Assumed trend factors	$ 789	$ 850
Assumed completion factors	553	51
Total	$ 1,342	$ 901

The favorable development recognized in the nine months ended September 30, 2023 resulted from trend factors in late 2022 developing more favorably than originally expected and completion factors in the latter parts of 2022 developing faster than expected. The favorable development recognized in the nine months ended September 30, 2022 resulted primarily from trend factors in late 2021 developing more favorably than originally expected.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 84.6% and 83.7% for the nine months ended September 30, 2023 and 2022, respectively. This ratio serves as an indicator of claims processing speed whereby speed for claims payments was slightly higher during the nine months ended September 30, 2023 as compared to the nine months ended September 30, 2022.

We calculate the percentage of prior year redundancies in the current period as a percent of prior year net medical claims payable less prior year redundancies in the current period in order to demonstrate the development of prior year reserves. For the nine months ended September 30, 2023, this metric was 9.6%, largely driven by favorable trend factor development at the end of 2022 as well as favorable completion factor development from 2022. For the nine months ended September 30, 2022, this metric was 7.3%, largely driven by favorable trend factor development at the end of 2021.

We calculate the percentage of prior year redundancies in the current period as a percent of prior year net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the nine months ended September 30, 2023, this metric was 1.2%, which was calculated using the redundancy of $1,342. For the nine months ended September 30, 2022, the comparable metric was 0.9%, which was calculated using the redundancy of $901. We believe these metrics demonstrate an appropriate level of reserve conservatism.

New Accounting Pronouncements

We adopted accounting standard amendments on long-duration insurance accounting which became effective for us on January 1, 2023, using the modified retrospective transition method for changes to the liability for future policy benefits and deferred acquisition costs as of the transition date, January 1, 2021. While the adoption did not have an overall material impact, our prior period financial statements presented in this Quarterly Report on Form 10-Q have been restated to reflect the impacts of our adoption as required by the new standard. For more information regarding this new accounting pronouncement that was adopted and new accounting pronouncements that were issued during the nine months ended September 30, 2023, see the "*Recently Adopted Accounting Guidance*" and *"Recent Accounting Guidance Not Yet Adopted"* sections of Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

Liquidity and Capital Resources

Sources and Uses of Capital

Our cash receipts result primarily from premiums, product revenue, service fees, investment income, proceeds from the sale or maturity of our investment securities, proceeds from borrowings and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, operating expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

For a more detailed overview of our liquidity and capital resources management, see the "*Introduction*" section included in the "Liquidity and Capital Resources" section of Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Exhibit 99.1 to this Quarterly Report on Form 10-Q.

For additional information regarding our sources and uses of capital during the three and nine months ended September 30, 2023, see Note 6, "Derivative Financial Instruments," Note 10, "Debt," and Note 12, "Capital Stock – *Use of Capital – Dividends and Stock Repurchase Program,*" of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Form 10-Q.

Liquidity

A summary of our major sources and uses of cash and cash equivalents for the nine months ended September 30, 2023 and 2022 is as follows:

	Nine Months Ended September 30		
	2023	2022	Change
Sources of Cash:			
Net cash provided by operating activities	$ 11,032	$ 9,917	$ 1,115
Issuances of short- and long-term debt, net of repayments	401	669	(268)
Proceeds from issuance of common stock under employee stock plans	112	152	(40)
Other sources of cash, net	—	23	(23)
Total sources of cash	11,545	10,761	784
Uses of Cash:			
Purchases of investments, net of proceeds from sales, maturities, calls and redemptions	(1,976)	(2,604)	628
Purchases of subsidiaries, net of cash acquired	(1,570)	(623)	(947)
Repurchase and retirement of common stock	(1,748)	(1,748)	—
Purchases of property and equipment	(970)	(854)	(116)
Cash dividends	(1,049)	(924)	(125)
Changes in bank overdrafts	(523)	—	(523)
Other uses of cash, net	(175)	—	(175)
Total uses of cash	(8,011)	(6,753)	(1,258)
Effect of foreign exchange rates on cash and cash equivalents	(2)	(16)	14
Net increase in cash and cash equivalents	$ 3,532	$ 3,992	$ (460)

The increase in net cash provided by operating activities was primarily due to higher net income in 2023, when excluding the non-cash impact of business optimization charges recognized in the third quarter of 2023, as well as the non-recurrence of the Subscriber Settlement Agreement payment made in September 2022.

Other significant changes in sources or uses of cash year-over-year included higher amounts for purchases of subsidiaries, net of cash acquired, a decrease in the issuance of short- and long term debt, net of repayments, a decline in bank overdrafts outstanding, an increase in the purchase of property and equipment and an increase in cash dividends. These additional uses of cash were partially offset by reduced purchases of investments, net of proceeds from sales, maturities, calls and redemptions.

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments in fixed maturity and equity securities of $39,711 at September 30, 2023. Since December 31, 2022, total cash, cash equivalents and investments in fixed maturity and equity securities increased by $4,667, primarily due to cash generated from operations, partially offset by cash used for the purchase of subsidiaries, cash used for the repurchase and retirement of common stock, the purchase of property and equipment and dividends paid to shareholders.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At September 30, 2023, we held $1,659 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Periodically, we access capital markets and issue debt ("Notes") for long-term borrowing purposes, for example, to refinance debt, to finance acquisitions or for share repurchases. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating. For more information on our debt, including redemptions and issuances, see Note 10, "Debt," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our consolidated balance sheets included in Part I, Item 1 of this Quarterly Report on Form 10-Q. Our debt-to-capital ratio is calculated as total debt divided by total debt plus total equity. Total debt is the sum of short-term borrowings, current portion of long-term debt and long-term debt, less current portion. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 39.2% and 39.9% as of September 30, 2023 and December 31, 2022, respectively.

Our senior debt is rated "A" by S&P Global Ratings, "BBB" by Fitch Ratings, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, liquidity, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Capital Resources

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

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. The 5-Year Facility provides for a credit of up to $4,000 and matures in April 2027. Our ability to borrow under the 5-Year Facility is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the credit agreement for the 5-Year Facility. We do not believe the restrictions contained in our 5-Year Facility covenants materially affect our financial or operating flexibility. We had no amounts outstanding under the 5-Year Facility as of September 30, 2023 or December 31, 2022. As of September 30, 2023, we were in compliance with all of the debt covenants under the 5-Year Facility.

We have an authorized commercial paper program of up to $4,000, the proceeds of which may be used for general corporate purposes. Should commercial paper issuance become unavailable, we have the ability to use a combination of cash on hand and/or our 5-Year Facility to redeem any outstanding commercial paper upon maturity. At September 30, 2023 and December 31, 2022, we had no commercial paper outstanding under our commercial paper program. Beginning June 30, 2023, we have reclassified our commercial paper balances, if any, from long-term debt to short-term debt as our intent is to not replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year.

While there is no assurance in the current economic environment, we believe the lenders participating in our 5-Year Facility, if market conditions allow, would be willing to provide financing in accordance with their legal obligations.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York (collectively the "FHLBs"). As a member, we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. We had $0 and $265 of outstanding short-term borrowings from the FHLBs at September 30, 2023 and December 31, 2022, respectively.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is

at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

For additional information regarding our sources and uses of capital at September 30, 2023, see Note 5, "Investments," Note 6, "Derivative Financial Instruments," Note 10, "Debt," and Note 12, "Capital Stock – *Use of Capital – Dividends and Stock Repurchase Program,*" of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q.

In addition to regulations regarding the timing and amount of dividends, our regulated subsidiaries' states of domicile have statutory risk-based capital ("RBC") requirements for health and other insurance companies and health maintenance organizations largely based on the National Association of Insurance Commissioners ("NAIC") Risk-Based Capital (RBC) for Health Organizations Model Act (the "RBC Model Act"). These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer's investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries' respective RBC levels as of December 31, 2022, which was the most recent date for which reporting was required, were in excess of all applicable mandatory RBC requirements. In addition to exceeding these RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries. For additional information, see Note 22, "Statutory Information," in our audited consolidated financial statements as of and for the year ended December 31, 2022 included in Part II, Item 8 of Exhibit 99.1 to this Quarterly Report on Form 10-Q.

Future Sources and Uses of Liquidity

We believe that cash on hand, future operating cash receipts, investments and funds available under our commercial paper program, our 5-Year Facility and borrowings available from the FHLBs will be adequate to fund our expected cash disbursements over the next twelve months.

There have been no material changes to our long-term liquidity requirements as disclosed in Part II, Item 7 of Exhibit 99.1 to this Quarterly Report on Form 10-Q. For additional updates regarding our estimated long-term liquidity requirements, see Note 6, "Derivative Financial Instruments," Note 10, "Debt," and the "*Other Contingencies*" and "*Contractual Obligations and Commitments*" sections of Note 11 "Commitments and Contingencies," of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q. We believe that funds from future operating cash flows, cash and investments and funds available under our 5-Year Facility and/or from public or private financing sources will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

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 healthcare laws and regulations, 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 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 pharmacy, healthcare 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.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

For a discussion of our market risks, refer to Item 7A, "Quantitative and Qualitative Disclosures about Market Risk," included in our 2022 Annual Report on Form 10-K. There have been no material changes to any of these risks since December 31, 2022.

ITEM 4. CONTROLS AND PROCEDURES

We carried out an evaluation as of September 30, 2023, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including the Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

There have been no changes in our internal control over financial reporting that occurred during the three months ended September 30, 2023 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

For information regarding legal proceedings at September 30, 2023, see the "*Litigation and Regulatory Proceedings,*" and "*Other Contingencies*" sections of Note 11, "Commitments and Contingencies" of the Notes to Consolidated Financial Statements included in Part I, Item 1 of this Quarterly Report on Form 10-Q, which information is incorporated herein by reference.

ITEM 1A. RISK FACTORS

There have been no material changes to the risk factors disclosed in our 2022 Annual Report on Form 10-K.

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES, USE OF PROCEEDS, AND ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities

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

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs[2]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
(in millions, except share and per share data)				
July 1, 2023 to July 31, 2023	502,279	$ 442.38	500,755	$ 5,386
August 1, 2023 to August 31, 2023	386,749	$ 464.83	385,456	5,207
September 1, 2023 to September 30, 2023	176,840	449.35	176,309	5,128
	1,065,868		1,062,520	

1 Total number of shares purchased includes 3,348 shares delivered to or withheld by us in connection with employee payroll tax withholding upon the exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated changes in equity are shown net of these shares purchased.

2 Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board of Directors evaluates periodically. During the three months ended September 30, 2023, we repurchased 1,062,520 shares at a total cost of $480 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. The most recent authorized increase to the program was $5,000 on January 24, 2023 by our Audit Committee, pursuant to authorization granted by the Board of Directors. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time.

ITEM 3. DEFAULTS UPON SENIOR SECURITIES

None.

ITEM 4. MINE SAFETY DISCLOSURES

None.

ITEM 5. OTHER INFORMATION

Recast 2022 Annual Financial Information

We are filing Exhibit 99.1 to this Quarterly Report on Form 10-Q to recast certain prior years' financial information and related disclosures to reflect changes to our reportable segments beginning in the first quarter of 2023, as well as the impact of the adoption of a new accounting standard related to the accounting for long-duration insurance contracts, which we adopted on January 1, 2023, using a modified retrospective transition method as of January 1, 2021. The recast financial information and related disclosures set forth in Exhibit 99.1 to this Quarterly Report on Form 10-Q present such financial information and related disclosures as they would have appeared had we changed our reportable segments and adopted the new accounting standard prior to January 1, 2023 and do not reflect events or developments that may have occurred subsequent to the filing of our 2022 Annual Report on Form 10-K.

The information contained in Exhibit 99.1 to this report is incorporated herein by reference.

Rule 10b5-1 Trading Plans

During the three months ended September 30, 2023, none of our directors or officers (as defined in Rule-1(f) of the Securities Exchange Act of 1934, as amended) adopted, modified or terminated a "Rule 10b5-1 trading arrangement" or "non-Rule 10b5-1 trading arrangement", as each term is defined in Item 408 of Regulation S-K.

ITEM 6. EXHIBITS

Exhibit Number			Exhibit
3.1			Amended and Restated Articles of Incorporation of the Company, as amended and restated effective June 27, 2022, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on June 28, 2022.
3.2			Bylaws of the Company, as amended effective October 4, 2023, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on October 5, 2023.
4.7			Upon the request of the U.S. Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
10.9	(d)	*	Form of Employment Agreement between the Company and Mark Kaye.
10.11		*	Offer Letter, by and between the Company and Mark Kaye, dated as of August 2, 2023, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on August 8, 2023.
23			Consent of Independent Registered Public Accounting Firm.
31.1			Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2			Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1			Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2			Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
99.1			Recast of certain financial information and related disclosures initially included in Part I, Item 1 "Business,", Part II Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part II Item 8. "Financial Statements and Supplementary Data" and Part IV Item 15 (c) "Financial Statement Schedule" of our Annual Report on Form 10-K for the year ended December 31, 2022, which was filed on February 15, 2023.
101			The following material from this Quarterly Report on Form 10-Q for the quarter ended September 30, 2023, formatted in Inline XBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Changes in Equity; (vi) Notes to Consolidated Financial Statements; and (vii) the information under Part II, Item 5, "Other Information." The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104			Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.

* Indicates management contracts or compensatory plans or arrangements.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

ELEVANCE HEALTH, INC.
Registrant

October 18, 2023 By: /S/ JOHN E. GALLINA

John E. Gallina
Executive Vice President and Chief Financial Officer
(Duly Authorized Officer and Principal Financial Officer)

October 18, 2023 By: /S/ RONALD W. PENCZEK

Ronald W. Penczek
Chief Accounting Officer and Controller
(Principal Accounting Officer)

Exhibit 31.1

CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Gail K. Boudreaux, certify that:

1. I have reviewed this report on Form 10-Q of Elevance Health, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

October 18, 2023

/s/ GAIL K. BOUDREAUX

President and Chief Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, John E. Gallina, certify that:

1. I have reviewed this report on Form 10-Q of Elevance Health, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

October 18, 2023

/s/ JOHN E. GALLINA

Executive Vice President and
Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Elevance Health, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2023 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Gail K. Boudreaux, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ GAIL K. BOUDREAUX

Gail K. Boudreaux
President and Chief Executive Officer
October 18, 2023

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Elevance Health, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2023 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, John E. Gallina, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN E. GALLINA

John E. Gallina
Executive Vice President and Chief Financial Officer
October 18, 2023

EXHIBIT 99.1

EXPLANATORY NOTE

Elevance Health, Inc. ("we," "our," "us," "Elevance Health" or the "Company") is filing this Exhibit 99.1 to this Quarterly Report on Form 10-Q to recast certain financial information and related disclosures included in Part I, Item 1 "Business," Part II Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part II Item 8 "Financial Statements and Supplementary Data" and Part IV Item 15 (c) "Financial Statement Schedule" of our Annual Report on Form 10-K for the year ended December 31, 2022, which was filed with the Securities and Exchange Commission ("SEC") on February 15, 2023 (our "2022 Form 10-K"), solely to reflect:

- *The changes to our reportable segments beginning in the first quarter of 2023, as described in the "General" section of Part I Item 1 "Business", the "Overview" section of Part II Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Note 1 "Organization" and Note 20 "Segment Information" included in Part II Item 8 "Financial Statements and Supplementary Data" of this Exhibit 99.1.*

- *The impact of the adoption of a new accounting standard related to the accounting for long-duration insurance contracts, which we adopted on January 1, 2023, using a modified retrospective transition method as of January 1, 2021, as described in Note 2 "Basis of Presentation and Significant Accounting Policies" included in Part II Item 8 "Financial Statements and Supplementary Data" of this Exhibit 99.1.*

These items did not have a material effect on the trends impacting our results of operations for 2021 compared to 2020. Accordingly, for the discussion of our results of operations for 2021 compared to 2020, see Part II Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K for the fiscal year ended December 31, 2021, which was filed with the SEC on February 16, 2022.

The recast financial information and related disclosures set forth in this Exhibit 99.1 are provided solely to present such financial information and related disclosures in these items as they would have appeared had we changed our reportable segments and adopted the new accounting standard prior to January 1, 2023. This Exhibit 99.1 does not reflect events or developments that may have occurred subsequent to the filing of our 2022 Form 10-K with the SEC and does not otherwise amend, update or modify any of the other disclosures made in our 2022 Form 10-K. Accordingly, the information in this Exhibit 99.1 should be read in conjunction with our 2022 Form 10-K and our subsequent filings with the SEC.

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 SEC 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 undertake to 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 healthcare laws and regulations, 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 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 pharmacy, healthcare 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

At Elevance Health, our purpose – to improve the health of humanity – is central to who we are. It inspires all we do and is the driving force behind our unique approach to health. We know to meaningfully improve health we must take a broader view. That is why our foundational approach looks at whole health and its most critical drivers: social, behavioral and physical. We believe in working together to achieve our mission of improving lives and communities, simplifying healthcare and expecting more. We strive to deliver on our mission by maximizing the power of partnerships, innovating to fuel growth and health equity, and having a high-performance culture. Our strategy is to become a lifetime, trusted health partner through the following four core focus areas:

- *Whole Health* – Partner to address physical, behavioral, social, and pharmacy needs to improve health, affordability, quality, equity, and access for individuals and communities.
- *Exceptional Experiences* – Put the people we serve at the center of all that we do, to exceed expectations and optimize health outcomes.
- *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 to improve efficiency and experiences, convert data into insights, and create a platform that connects stakeholders from across the health ecosystem.

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

- *Leadership* – Redefine what is possible
- *Community* – Committed, connected, invested
- *Integrity* – Do the right thing, with a spirit of excellence
- *Agility* – Deliver today, transform tomorrow
- *Diversity* – Open our hearts and minds

We are one of the largest health insurers in the United States in terms of medical membership, serving approximately 47.5 million medical members through our affiliated health plans as of December 31, 2022. 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 and 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 unaffiliated health plans, including pharmacy services and 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, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. In addition, we conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states as Amerigroup, Freedom Health, HealthLink, HealthSun, MMM, Optimum Healthcare, Simply Healthcare, UniCare and/or Wellpoint. We offer pharmacy services as CarelonRx and other health-care related services as Carelon Services, Aspire Health, Carelon Behavioral Health and Caremore. We are licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through our subsidiaries.

As part of our name change to Elevance Health, in June 2022, we announced that over the next several years we will organize 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 formerly named Diversified Business Group and IngenioRx 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. As a result, we changed our reportable segments to the following beginning in the first quarter of 2023: 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).

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 Exhibit 99.1.

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 they 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, other demographic characteristics and the COVID-19 pandemic 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 general and administrative costs continues to be a driver of our overall profitability.

Our future results of operations will also 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 our 2022 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 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 COVID-19, including how our members access healthcare services, or our exit from a specific market. See Part I, Item 1A "Risk Factors" included in our 2022 Form 10-K and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Exhibit 99.1.

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 28% of our total consolidated revenues from agencies of the U.S. government for each of the years ended December 31, 2022, 2021 and 2020. 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

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 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 services such as formulary management, pharmacy networks, specialty and home delivery pharmacy services and member services.

Our Carelon Services segment is focused on lowering the cost and improving the quality of healthcare by enabling and creating new care delivery and payment models, with a special emphasis on serving those with complex and chronic conditions. Carelon Services offers a broad array of healthcare-related services and capabilities to internal and external customers including integrated care delivery, behavioral health, palliative care, utilization management, payment integrity services and subrogation services, as well as health and wellness programs.

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 Exhibit 99.1.

Membership

Our medical membership includes seven different 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.

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.

In 2022, we made the decision to expand our participation in the Public Exchange market for 2023 after also expanding in 2022. As a result, for 2023 we are offering Individual Public Exchange products in 138 of the 143 rating regions in which we operate, in comparison to 122 of 143 rating regions in 2022. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment and underlying market characteristics.

Being a licensee of the BCBS association of companies, of which there were 34 independent primary licensees including us as of December 31, 2022, 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, as well as HealthLink and UniCare members.

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 Exhibit 99.1.

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 a demonstration program 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. As of December 31, 2022, we provide Medicaid and other state sponsored services, such as administrative services, in Arkansas, California, Colorado, 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 features such as formulary management, pharmacy networks, a prescription drug database, member services and mail order capabilities.

CarelonRx delegates certain pharmacy services, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement that is set to terminate on December 31, 2024. With CarelonRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy. From December 2009 through December 2019, we delegated certain pharmacy functions and administrative services to Express Scripts Inc. ("Express Scripts"). We transitioned existing members from Express Scripts to CarelonRx by January 1, 2020.

Carelon Services

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

- *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.
- *Advanced Analytics and Services.* We leverage data, analytics, and insights to help improve outcomes and lower the cost of care, by working to ensure that our members receive safe, appropriate, high-quality, cost-effective care and that our providers are reimbursed accurately and timely.

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 benefit managers, 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 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 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 wellbeing. 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. 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 condition, 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 AIM Specialty Health ("AIM") subsidiary, we promote appropriate, safe and affordable member care in the areas of 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 overall healthcare delivered to our members and members of other health plans that are covered under AIM's programs.

Through our myNEXUS, Inc. ("myNEXUS") subsidiary, we perform management review for home health 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, myNEXUS has developed programs to address healthcare quality by identifying social determinants of health needs of our members and seeking to close gaps in care through an in-home assessment. Both AIM and myNEXUS 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"), 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 our 2022 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 Exhibit 99.1 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 and departments of health, insurance and corporation, 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 recovery of 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 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 our 2022 Form 10-K.

COVID-19

With the declaration of COVID-19 as a public health emergency ("PHE"), the federal and state governments have enacted, and may continue to enact, legislation and regulations in response to the COVID-19 pandemic that have had, and we expect will continue to have, a significant impact on health benefits, consumer eligibility for public programs and our cash flows for all lines of business, and which have introduced increased uncertainty around our cost structure. These actions, which are or have been in effect for various durations, provide, among other things: mandates to waive cost-sharing for COVID-19 testing, vaccines and related services; financial support to healthcare providers; and mandates related to prior authorizations, payment levels to providers, consumer enrollment windows and telehealth services. The Biden administration renewed the PHE on January 11, 2023 and has indicated that they intend for the PHE to expire on May 11, 2023.

Under the Consolidated Appropriations Act of 2023, Congress decoupled Medicaid eligibility recertification from the PHE. As a result, states may begin removing ineligible beneficiaries from their Medicaid programs starting April 1, 2023. When recertifications resume, we expect a decline in our Medicaid membership. At the same time, we expect growth in our commercial risk-based and fee-based plans and Medicare, including through the Public Exchanges, as members exiting Medicaid in our 14 commercial states seek coverage elsewhere.

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 will likely allow for growth in Individual exchange market enrollment as Medicaid eligibility recertifications resume, 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 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 of which have been 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, 2022, 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 Exhibit 99.1.

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 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. Approximately 53.6% and 18.4% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2021.
- 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. For payment year 2023, we expect to have approximately 73% of our Medicare Advantage members in 4.0 or higher rated plans.
- 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 adjustments to our premium rates and geographic participation, including a modest expansion in the Public Exchange markets in 2022 and further expansion into a limited number of additional counties 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. As a result, for 2023 we are offering Individual Public Exchange products in 138 of the 143 rating regions in which we operate, in comparison to 122 of 143 rating regions in 2022. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment and underlying market characteristics.

Drug Benefit and Pharmacy Benefit Manager Regulation

Pharmacy benefit managers ("PBMs") are regulated at both the federal and state levels and must comply with federal and state statutes and regulations governing labeling, packaging, advertising and adulteration of prescription drugs, dispensing of controlled substances and licensing. In recent years the federal government has banned certain business practices, including "gag clauses," which prohibited pharmacists from informing patients when a lower cost drug was available as a substitute, and "clawbacks," which occurred when pharmacy benefit managers 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 pharmacy benefit manager, and licensure accompanied by additional disclosures and limitations of business practices to varying degrees. The NAIC finalized a PBM model law that, if adopted widely, could result in a more standardized approach to PBM regulation in the states in the future. Additionally, in December 2020, the U.S. Supreme Court let stand an Arkansas law regulating PBMs, which could be a precursor to greater state regulation of PBMs in the future. In June 2021, the NAIC announced a proposed white paper addressing PBMs and examining the impact of this Supreme Court case on its model law, which could result in expansion of the NAIC model law and additional regulatory oversight, which could materially affect current industry practices and our PBM business.

A number of proposals are being considered at the federal and state levels that would increase regulation of drug benefits and pharmacy benefit managers. Such proposals under consideration include (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, and (5) electronic prior authorizations of drugs. These reforms have the potential to have broad impacts on our PBM business and could materially adversely affect our business if they are enacted.

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.

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 benefit managers 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 planning potential revisions to one or more of its privacy model acts, 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; 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 are now 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. In 2024, this requirement will expand to 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 back-office 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 and anti-money laundering.

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, 2022, our employee population, including all full-time, part-time and temporary workers, consisted of approximately 102,300 individuals, 79,000 in the United States and 23,300 internationally. We have built a high-performance culture that we believe 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. Our associates actively participate through associate engagement surveys and online feedback tools. We leverage and monitor associate feedback and take action on responses.

Inclusion & Diversity

The diversity of our associates is central to achieving key strategies and improving performance. We strive to maintain 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. As of December 31, 2022, our U.S. associate population was approximately 77% female and 51% racially and ethnically diverse, while 65% of our managers are female and 36% are racially or ethnically diverse.

Fair Pay

Elevance Health is 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 is within 1% of their male counterparts and pay for people of color 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.

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 programs and tools to help them get and stay healthy and more easily manage their work and personal lives.

Information About Our Executive Officers

The following sets forth certain information regarding our executive officers and Chief Accounting Officer as of February 1, 2023.

Name	Age	Position
Gail K. Boudreaux	62	President and Chief Executive Officer
John E. Gallina	63	Executive Vice President and Chief Financial Officer
Peter D. Haytaian	53	Executive Vice President and President, Carelon and CarelonRx
Charles M. Kendrick, Jr.	57	Executive Vice President and President, Commercial & Specialty Business Division
Gloria M. McCarthy	70	Executive Vice President and Chief Administrative Officer
Felicia F. Norwood	63	Executive Vice President and President, Government Business Division
Blair W. Todt	55	Executive Vice President and Chief Legal Officer
Ronald W. Penczek	58	Chief Accounting Officer and Controller

Ms. Boudreaux has served as our President and Chief Executive Officer and a Director of the Company since November 2017. Prior to joining us, she served as Chief Executive Officer of GKB Global Health, LLC (healthcare consulting firm) from 2015 to November 2017. Prior thereto, Ms. Boudreaux was Executive Vice President of UnitedHealth Group Incorporated (diversified healthcare company) from 2008 to 2015, including roles as Chief Executive Officer of UnitedHealthCare (managed healthcare company), a subsidiary of UnitedHealth Group Incorporated from 2011 to 2014 and President of the Commercial Business of UnitedHealthCare from 2008 to 2011. Before joining United HealthCare, she worked at Health Care Service Corporation ("HCSC") (health insurance company) as Executive Vice President of External Operations from 2005 to 2008 and President of Blue Cross and Blue Shield of Illinois from 2002 to 2005. Before joining HCSC, Ms. Boudreaux held various positions at Aetna, Inc. ("Aetna") (managed healthcare company), including Senior Vice President, Group Insurance.

Mr. Gallina has served as our Executive Vice President and Chief Financial Officer since 2016. Mr. Gallina joined Elevance Health in 1994 and has held a variety of leadership roles across the organization. Prior to his current role, Mr. Gallina served as Elevance Health's Chief Financial Officer for the Commercial & Specialty Business Division from 2015 to 2016, and as Senior Vice President and Chief Accounting Officer from 2013 to 2015. Other leadership positions held during his tenure include Senior Vice President, Chief Accounting Officer and Chief Risk Officer from 2011 to 2013, while also holding the title of Controller from 2011 to 2013. Before joining the Company, Mr. Gallina spent 12 years with Coopers & Lybrand in various positions, including as an Audit Senior Manager.

Mr. Haytaian has served as our Executive Vice President and President of Carelon (formerly known as our Diversified Business Group) and CarelonRx (formerly known as IngenioRx) since October 2021. Prior to his current role, Mr. Haytaian served as Executive Vice President and President of our Commercial & Specialty Business Division beginning in April 2018. From June 2014 until April 2018, Mr. Haytaian served as our Executive Vice President and President of the Government Business Division. Mr. Haytaian joined the Company in 2012 with our acquisition of Amerigroup Corporation ("Amerigroup") and served as President of our Medicaid business from 2013 until 2014. From 2005 to 2013, Mr. Haytaian held several leadership positions with Amerigroup, including serving as Chief Executive Officer of the North Region for Amerigroup's Medicaid business from 2012 until 2013. Mr. Haytaian has extensive experience leading Medicare and Medicaid programs with Amerigroup and, prior thereto, with Oxford Health Plans, Inc.

Mr. Kendrick has served as Executive Vice President and President of our Commercial & Specialty Business Division since October 2021. From January 2021 until October 2021, Mr. Kendrick served as President of our Commercial Business West Markets (California, Colorado, Indiana, Kentucky, Missouri, Nevada, Ohio and Wisconsin). Mr. Kendrick joined us in 1995, and has held numerous leadership roles across the organization, including serving as President, Anthem National Accounts/Central Markets from 2015 until January 2021 and President of National Accounts and General Manager for Anthem Blue Cross and Blue Shield of Georgia from 2010 until 2015.

Ms. McCarthy has served as our Executive Vice President and Chief Administrative Officer since 2013. She was Executive Vice President of Enterprise Execution and Efficiency from 2012 to 2013. Prior to that appointment, she served as Senior Vice President for Operational Excellence from 2008 to 2012, as Senior Vice President of Service Operations from 2006 to 2008 and as Senior Vice President and Chief Operating Officer of our East Region from 2005 to 2006. Prior to our acquisition of WellChoice, Inc. ("WellChoice") in 2005, Ms. McCarthy served as Executive Vice President and Chief Operating Officer of WellChoice.

Ms. Norwood has served as our Executive Vice President and President of the Government Business Division since June 2018. Prior to joining us, she was Director of The Department of Healthcare and Family Services for the State of Illinois from 2015 to June 2018. Prior to that appointment, Ms. Norwood held a variety of leadership roles at Aetna, with her most recent role as President of the Mid-America Region for Aetna from 2010 until 2013.

Mr. Todt has served as our Executive Vice President and Chief Legal Officer since November 2020 and our interim head of human resources and global security and safety team since January 2022. Prior to joining us, Mr. Todt served as Senior Vice President, Legal, Compliance & Business Performance and Chief Legal Officer of HCSC from 2016 to July 2020. Prior to joining HCSC, Mr. Todt held a variety of leadership roles at WellCare Health Plans, Inc. (health insurance company), with his most recent role as Senior Vice President, Chief Legal and Administrative Officer and Secretary from 2010 until 2016.

Mr. Penczek has served as our Controller since November 2015 and as our Chief Accounting Officer since December 2015. He served as our Vice President and Controller from 2013 to 2015. Prior to that appointment, Mr. Penczek served as Vice President and Assistant Controller from 2008 to 2013 and in various other roles in our finance department from 2006 until 2008. Before joining us in 2005, Mr. Penczek was a Staff Vice President with CNA Insurance from 2000 to 2005 and had various positions with PricewaterhouseCoopers LLP from 1992 to 2000, including as a Manager.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended (the "Exchange Act")) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission ("SEC"). The SEC maintains a website that contains reports, proxy and information statements and other information regarding issuers at www.sec.gov. Our website is www.elevancehealth.com. We have included our website address throughout this Exhibit 99.1 as a textual reference only. The information contained on, or accessible through, our website is not incorporated into this Exhibit 99.1 or any of our other SEC filings. We make available through our website, free of charge, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our website our Corporate Governance Guidelines, our Code of Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our website any amendments to, or waivers from, our Code of Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange. Elevance Health, Inc. is an Indiana corporation incorporated on July 17, 2001.

PART II

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

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

On May 18, 2022, our shareholders approved a proposal to amend our amended and restated articles of incorporation to change our name from Anthem, Inc. to Elevance Health, Inc. This amendment and name change went into effect on June 27, 2022. We began operating as Elevance Health, Inc. and trading under our new ticker symbol "ELV" on June 28, 2022. References to the terms "we," "our," "us," "Elevance Health" or the "Company" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") refer to Elevance Health, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia and Puerto Rico, unless the context otherwise requires.

This MD&A should be read in conjunction with our audited consolidated financial statements included in Part II, Item 8 of this Exhibit 99.1.

This MD&A generally discusses 2022 and 2021 items and year-over-year comparisons between 2022 and 2021. A detailed discussion of 2020 items and year-over-year comparisons between 2021 and 2020 that are not included in this Exhibit 99.1 can be found in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2021.

Overview

Elevance Health is a health company with the purpose of improving the health of humanity. We are one of the largest health insurers in the United States in terms of medical membership, serving approximately 47.5 million medical members through our affiliated health plans as of December 31, 2022. 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, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. In addition, we conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states as Amerigroup, Freedom Health, HealthLink, HealthSun, MMM, Optimum Healthcare, Simply Healthcare, UniCare and/or Wellpoint. We offer pharmacy services as CarelonRx and other health-care related services as Carelon Services, Aspire Health, Carelon Behavioral Health and Caremore. We are licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through our subsidiaries.

As part of our name change to Elevance Health, in June 2022, we announced that over the next several years we will organize 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 formerly named Diversified Business Group and IngenioRx 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. As a result, we changed our reportable segments to the following beginning in the first quarter of 2023: 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).

The results of operations discussed in this MD&A have been recast and are presented as they would have appeared had we changed our reportable segments and adopted the new accounting standard discussed in the "Explanatory Note" above prior to January 1, 2023.

Our results of operations discussed throughout this MD&A are determined in accordance with generally accepted accounting principles ("GAAP"). We also calculate operating gain and operating margin to further aid investors in understanding and analyzing our core operating results. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and operating expense. Operating margin is calculated as operating gain divided by operating revenue. Our definition of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating periods and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or fully-diluted earnings per share ("EPS") prepared in accordance with GAAP. For additional details on operating gain, see our "Reportable Segments Results of Operations" discussion included in this MD&A. For a reconciliation of reportable segment operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of reportable segment operating gain to income before income tax expense, see Note 20, "Segment Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Our operating revenue consists of premiums, product revenue, and service fees. Premium revenue is generated from risk-based contracts where we indemnify our policyholders against costs for covered health and life insurance benefits. Product revenue represents services performed by CarelonRx for unaffiliated pharmacy customers and includes ingredient costs (net of any rebates or discounts), including co-payments made by or on behalf of the customer, and service fees. Unaffiliated pharmacy customers include our fee-based employer groups that contract with CarelonRx for pharmacy services and external customers outside of the health plans we own. Service fees come from fees from our fee-based customers for the processing of transactions or network discount savings realized, revenues from our Medicare processing business and revenues from other health-related businesses, including care management programs and miscellaneous other income.

Our benefit expense primarily includes costs of care for health services consumed by our risk-based members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: Preferred Provider Organizations; Health Maintenance Organizations; Point-of-Service plans; traditional indemnity plans and other hybrid plans, including Consumer-Driven Health Plans; and hospital only and limited benefit products.

We classify certain quality improvement costs as benefit expense. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members. These quality improvement costs may be comprised of expenses incurred for: (i) medical management, including care coordination and case management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy, such as identification and use of best clinical practices to avoid harm, identifying clinical errors and safety concerns, and identifying potential adverse drug interactions.

Our cost of products sold represents the cost of pharmaceuticals dispensed by CarelonRx for our unaffiliated pharmacy customers (net of rebates or discounts), including any co-payments made by or on behalf of the customer, per-claim

administrative fees for prescription fulfillment and certain direct costs related to sales and administration of customer contracts.

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

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

We intend to expand through a combination of organic growth, strategic acquisitions and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale, as well as provide us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. We market and offer pharmacy services through CarelonRx and other subsidiaries, and we expect CarelonRx to continue to improve our ability to integrate pharmacy benefits within our medical and specialty platform. We continued growing our government-sponsored business through organic growth and the acquisitions of MMM Holdings, LLC ("MMM") in 2021 and Integra MLTC, Inc. ("Integra") in 2022. In all other markets, we intend to maintain our position by delivering excellent service, offering competitively priced products, providing access to high-quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

For additional information about our business and reportable segments, see Part I, Item 1 "Business" and Note 20, "Segment Information" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

COVID-19

The COVID-19 pandemic continues to evolve, putting pressure on the healthcare system, and it has impacted, and may continue to impact, our membership, benefit expense and member behavior. The full extent of the impact of the COVID-19 pandemic will depend on future developments, which remain uncertain and cannot be predicted at this time. We will continue to monitor the COVID-19 pandemic as well as resulting legislative and regulatory changes to manage our response and assess and mitigate potential adverse impacts to our business. For additional discussion regarding the impact of and our risks and trends related to the COVID-19 pandemic, see "Business Trends" below and Part I, Item 1A "Risk Factors" in our 2022 Form 10-K.

Business Trends

In 2022, we made the decision to modestly expand our participation in the Individual state- or federally-facilitated marketplaces (the "Public Exchange") for 2023 after also expanding in 2022. As a result, for 2023 we are offering Individual Public Exchange products in 138 of the 143 rating regions in which we operate, in comparison to 122 of 143 rating regions in 2022. Our strategy has been, and will continue to be, to only participate in rating regions where we have an appropriate level of confidence that these markets are on a path toward sustainability, including, but not limited to, factors such as expected financial performance, regulatory environment and underlying market characteristics. Changes to our business environment are likely to continue as elected officials at the national 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. In addition, the continuing growth in our government-sponsored business exposes us to increased regulatory oversight.

Our CarelonRx subsidiary markets and offers PBM services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. Our comprehensive PBM services portfolio includes features such as formulary management, pharmacy networks, a prescription drug database, member services and mail order capabilities. CarelonRx delegates certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement that is set to terminate on December 31, 2024. With CarelonRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy.

Pricing Trends: We strive to price our health benefit products consistent with anticipated underlying medical cost trends. We continue to closely monitor the COVID-19 pandemic (including new COVID-19 variants, which may be more contagious or severe, or less responsive to treatment or vaccines) and the impacts it may have on our pricing, such as surges in COVID-19 related hospitalizations, infection rates, the cost of COVID-19 vaccines, testing and treatment and the return of non-COVID-19 healthcare utilization to our estimate of normal levels, based on historical utilization patterns. We frequently make adjustments to respond to legislative and regulatory changes as well as pricing and other actions taken by existing competitors and new market entrants. Product pricing in our Employer Group risk-based business remains competitive. Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The Patient Protection and Affordable Care Act (the "ACA") imposed an annual Health Insurance Provider Fee ("HIP Fee") on health insurers that write certain types of health insurance on U.S. risks. We priced our affected products to cover the impact of the HIP Fee when it was in effect. The HIP Fee was in effect for 2020 but was permanently repealed beginning in 2021.

Medical Cost Trends: Our medical cost trends are primarily driven by increases in the utilization of services across all provider types and the unit cost increases of these services. We work to mitigate these trends through various medical management programs such as care and condition management, program integrity and specialty pharmacy management and utilization management, as well as benefit design changes. There are many drivers of medical cost trends that can cause variance from our estimates, such as changes in the level and mix of services utilized, regulatory changes, aging of the population, health status and other demographic characteristics of our members, epidemics, pandemics, advances in medical technology, new high cost prescription drugs, provider contracting inflation, labor costs and healthcare provider or member fraud.

At its onset, the COVID-19 pandemic caused a decrease in utilization of non-COVID-19 health services, which decreased our claim costs in 2020. As the pandemic continued through 2021, our non-COVID-19 healthcare utilization experience gradually increased and largely normalized, and our COVID-19 related healthcare expenses increased as new variants (Delta and Omicron) emerged and vaccinations and boosters became available.

The Omicron variant increased confirmed COVID-19 cases to significant levels at the end of 2021 and the beginning of 2022. The COVID-19 surge quickly declined during the first quarter of 2022, with COVID-19 inpatient hospitalizations, provider-based tests, visits and vaccinations all decreasing to lower levels by the end of the first half of 2022; concurrently, non-COVID-19 healthcare utilization recovered from lower levels earlier in the year. Omicron sub-variant viruses as well as costs associated with updated bivalent vaccinations drove modest increases in COVID-19 related healthcare expenses in the second half of 2022, but the expected paid claims impact for the second half of 2022 are significantly lower than the winter surge experienced in each of the prior two years. The ongoing cost and volume of covered services related to the COVID-19 pandemic and a future shift of government supplied vaccinations and treatments to privatized, full cost price points may have an adverse effect on our future claim costs. We continue to closely monitor the COVID-19 pandemic and its impacts on our medical cost trends.

For additional discussion regarding business trends, see Part I, Item 1 "Business" of this Exhibit 99.1.

Regulatory Trends and Uncertainties

With the declaration of COVID-19 as a public health emergency ("PHE"), the federal and state governments enacted, and may continue to enact, legislation and regulations in response to the COVID-19 pandemic that have had, and we expect will continue to have, a significant impact on health benefits, consumer eligibility for public programs and our cash flows for all of our lines of business and which have introduced increased uncertainty around our cost structure. These actions, which are or have been in effect for various durations, provide, among other things: mandates to waive cost-sharing for COVID-19 testing, vaccines and related services; financial support to healthcare providers; and mandates related to prior authorizations, payment levels to providers, consumer enrollment windows and telehealth services. The Biden administration renewed the PHE on January 11, 2023 and has indicated that they intend for the PHE to expire on May 11, 2023.

Under the Consolidated Appropriations Act of 2023, Congress decoupled Medicaid eligibility recertification from the PHE. As a result, states may begin removing ineligible beneficiaries from their Medicaid programs starting April 1, 2023. When recertifications resume, we expect a decline in our Medicaid membership. At the same time, we expect growth in our commercial risk-based and fee-based plans and Medicare, including through the Public Exchanges, as members exiting Medicaid in our 14 commercial states seek coverage elsewhere.

The Inflation Reduction Act of 2022, 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 the Centers for Medicare and Medicaid Services ("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 will likely allow for growth in Individual exchange market enrollment as Medicaid eligibility recertifications resume, supporting continuity of coverage for more people.

The Consolidated Appropriations Act of 2021 (the "2021 Appropriations Act") has impacted 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 of which have been extended into 2023 since the enactment of the 2021 Appropriations Act.

The health plan price transparency regulations issued in October 2020 by the U.S. Departments of Health and Human Services, Labor and Treasury required us to begin disclosing in July 2022, 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 are now 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. In 2024, this requirement will expand to all items and services.

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 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.

For additional discussion regarding regulatory trends and uncertainties, and risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Exhibit 99.1, see Part I, Item 1 "Business — *Regulation*" in this Exhibit 99.1 and Part I, Item 1A "Risk Factors" in our 2022 Form 10-K.

Other Significant Items

Business and Operational Matters

As mentioned above, we began operating as Elevance Health on June 28, 2022. This name change is intended to better reflect our business and our journey from a traditional health benefits organization to a lifetime, trusted health partner. Elevance Health supports health at every stage, offering health plans and clinical, behavioral, pharmacy and complex-care solutions that promote whole health.

On January 23, 2023, we announced our entrance into an agreement to acquire Louisiana Health Service & Indemnity Company, d/b/a Blue Cross and Blue Shield of Louisiana, an independent licensee of the BCBSA that provides healthcare plans to the Individual, Employer Group, Medicaid and Medicare markets, primarily in the State of Louisiana. This acquisition aligns with our vision to be an innovative, valuable, and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. The acquisition is expected to close by the end of the fourth quarter of 2023 and is subject to standard closing conditions and customary approvals.

On November 9, 2022, we announced our entrance into an agreement with CarepathRx Aggregator, LLC to acquire its specialty pharmacy division, which includes BioPlus Parent, LLC ("BioPlus") and subsidiaries. BioPlus is one of the largest independent specialty pharmacy organizations in the United States and seeks to connect payors and providers of specialty pharmaceuticals to meet the medication therapy needs of patients with complex medical conditions. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. The acquisition closed on February 15, 2023, and initial purchase accounting has not been finalized.

On May 5, 2022, we completed our acquisition of Integra. Integra is a managed long-term care plan that serves New York state Medicaid members, enabling adults with long-term care needs and disabilities to live safely and independently in their own homes.

On June 29, 2021, we completed our acquisition of MMM, including its Medicare Advantage plan, Medicaid plan and other affiliated companies. MMM is a Puerto Rico-based integrated healthcare organization and seeks to provide its Medicare Advantage and Medicaid members with a whole health experience through its network of specialized clinics and wholly owned independent physician associations. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve.

On April 28, 2021, we completed our acquisition of myNEXUS, Inc. ("myNEXUS"). myNEXUS is a comprehensive home-based nursing management company for payors and, at the time of acquisition, delivered integrated clinical support services for Medicare Advantage members across twenty states. This acquisition aligns with our strategy to manage integrated, whole person multi-site care and support by providing national, large-scale expertise to manage nursing services in the home and facilitate transitions of care.

For additional information, see Note 3, "Business Acquisitions," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

In 2020, we introduced enterprise-wide initiatives to optimize our business and as a result, recorded a charge of $653 in operating expense. We believe these initiatives largely represent the next step forward in our progression towards becoming a more agile organization, including process automation and a reduction in our office space footprint. In the fourth quarters of 2022 and 2021, we identified additional office space reductions and related fixed asset impairments due to the continuing COVID-19 pandemic and recorded net charges of $39 and $202, respectively, in operating expense. For additional information, see Note 4, "Business Optimization Initiatives" and Note 18, "Leases" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Litigation Matters

In the consolidated multi-district proceeding in the United States District Court for the Northern District of Alabama (the "Court") captioned *In re Blue Cross Blue Shield Antitrust Litigation* ("BCBSA Litigation"), the BCBSA and Blue Cross and/or Blue Shield licensees, including us (the "Blue plans") previously approved a settlement agreement and release with the

plaintiffs representing a putative nationwide class of health plan subscribers (the "Subscriber Settlement Agreement"), which agreement required the Court's approval to become effective. Generally, the lawsuits in the BCBSA Litigation challenge elements of the licensing agreements between the BCBSA and the independently owned and operated Blue plans. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers. The Subscriber Settlement Agreement applies only to the subscriber class. The defendants continue to contest the consolidated cases brought by the provider plaintiffs.

In August 2022, the Court issued a final order approving the Subscriber Settlement Agreement (the "Final Approval Order"). In compliance with the Subscriber Settlement Agreement, the Company paid $506 into an escrow account in September 2022, for an aggregate and full settlement payment by the Company of $596, which was previously accrued in 2020. Four notices of appeal of the Final Approval Order were filed by the September 2022 appeal deadline. Those appeals are proceeding in the United States Court of Appeals for the Eleventh Circuit. In the event all appellate rights are exhausted in a manner that affirms the Court's Final Approval Order, the defendants' payment and non-monetary obligations under the Subscriber Settlement Agreement will become effective and the funds held in escrow will be distributed in accordance with the Subscriber Settlement Agreement. For additional information regarding the BCBSA Litigation, see Note 14, "Commitments and Contingencies – *Litigation and Regulatory Proceedings – Blue Cross Blue Shield Antitrust Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Selected Operating Performance

During the year ended December 31, 2022, total medical membership increased by 2.2 million, or 4.8%. The increase in medical membership was driven primarily by organic growth due to the continued temporary suspension of Medicaid eligibility recertification during the COVID-19 pandemic, as well as organic growth in our Employer Group fee-based membership.

Operating revenue for the year ended December 31, 2022 was $155,660, an increase of $18,717, or 13.7%, from the year ended December 31, 2021. The increase in operating revenue was primarily driven by higher premium revenue in our Medicaid business due to organic membership growth from the continued temporary suspension of Medicaid eligibility recertification during the COVID-19 pandemic, the acquisition of Integra in the second quarter of 2022 and the acquisition of Ohio Medicaid members through the purchase of a Medicaid contract in the first quarter of 2022. Membership growth in our Medicare Advantage and commercial risk-based businesses, as well as premium rate increases to cover medical cost trends, also generated higher premium revenue. Finally, the increase in operating revenue was further attributable to increased pharmacy product revenue in our CarelonRx segment, resulting from growth in membership and higher script volume.

Net income for the year ended December 31, 2022 was $5,888, a decrease of $261, or 4.2%, from the year ended December 31, 2021. The decrease in net income was primarily due to realized losses on financial instruments in 2022, as compared to gains in 2021, and increased intangible amortization in 2022 related to recent acquisitions and the rebranding of our products, as we expect to retire certain trade names in the future. These items were partially offset by operating gain increases in all of our business segments.

Our fully-diluted shareholders' earnings per share ("EPS") for the year ended December 31, 2022 was $24.28, a decrease of $0.67, or 2.7%, from the year ended December 31, 2021. Our diluted shares for the year ended December 31, 2022 were 242.8, a decrease of 4.0, or 1.6%, compared to the year ended December 31, 2021. The decrease in EPS resulted from the decline in net income, partially offset by the impact of lower average shares outstanding in 2022.

Operating cash flow for the year ended December 31, 2022 was $8,399, or approximately 1.4 times net income. Operating cash flow for the year ended December 31, 2021 was $8,364, or approximately 1.4 times net income. The slight increase in operating cash flow was primarily due to higher net income in 2022, when adjusted for the impact of investment losses and gains, partially offset by the timing of working capital changes and the payment pursuant to the Subscriber Settlement Agreement made in September 2022.

Membership

Our medical membership includes the following customer types: Individual, Employer Group risk-based, Employer Group fee-based, BlueCard®, Medicare, Medicaid and our Federal Employees Health Benefits ("FEHB") Program. 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, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Public Exchanges. Individual business is sold on a risk-based basis. We offer on-exchange products through Public Exchanges and off-exchange products. Federal premium subsidies are available only for certain Public Exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Customer turnover is generally higher with Individual as compared to Employer Group risk-based. Individual business accounted for 1.7%, 1.7% and 1.6% of our medical members at December 31, 2022, 2021 and 2020, respectively.
- Employer Group risk-based consists of employer customers who purchase products on a full-risk basis, which are products for which we charge a premium and indemnify our policyholders against costs for health benefits. Employer Group risk-based accounts include Local Group customers and National Accounts. Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes Student Health members. National Accounts generally consist of multi-state employer groups primarily headquartered in an Elevance Health service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Employer Group risk-based accounts are generally sold through brokers or consultants who work with industry specialists from our in-house sales force and are offered both on and off the Public Exchanges. Employer Group risk-based accounted for 8.4%, 8.8% and 8.9% of our medical members at December 31, 2022, 2021 and 2020, respectively.
- Employer Group fee-based customers represent employer groups, Local Group, including UniCare members, and National Accounts, who purchase fee-based products and elect to retain most or all of the financial risk associated with their employees' healthcare costs. Some fee-based customers choose to purchase stop loss coverage to limit their retained risk. Employer Group fee-based accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. Employer Group fee-based accounted for 42.4%, 42.7% and 45.5% of our medical members at December 31, 2022, 2021 and 2020, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Elevance Health who receive healthcare services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Elevance Health subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Elevance Health controlled BCBSA licensee (the "home plan"). We perform certain functions, including claims pricing and administration, for BlueCard® members, 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. Host members are computed using, among other things, the average number of BlueCard® claims received per month. BlueCard® host membership accounted for 13.6%, 13.6% and 14.1% of our medical members at December 31, 2022, 2021 and 2020, respectively.
- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, including Special Needs Plans ("SNPs"), also known as Medicare Advantage 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 retired members of groups who are not affiliated with our commercial accounts who have selected a Medicare Advantage product through us. Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP, which was established as a result of the passage of the ACA, is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare program business accounted for 6.2%, 6.2% and 5.5% of our medical members at December 31, 2022, 2021 and 2020, respectively.

- Medicaid membership represents eligible members who receive health benefits through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities, among others. Total Medicaid program business accounted for 24.3%, 23.4% and 20.6% of our medical members at December 31, 2022, 2021 and 2020, respectively.
- FEHB members consist of United States government employees and their dependents who receive health benefits within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management. FEHB business accounted for 3.4%, 3.6% and 3.8% of our medical members at December 31, 2022, 2021 and 2020, respectively.

The following table presents our medical membership by reportable segment and customer type as of December 31, 2022, 2021 and 2020. Also included below is other membership by product. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

	December 31			2022 vs. 2021		2021 vs. 2020	
(In thousands)	**2022**	**2021**	**2020**	**Change**	**% Change**	**Change**	**% Change**
Medical Membership							
Individual	789	759	680	30	4.0 %	79	11.6 %
Employer Group Risk-Based	3,988	4,006	3,799	(18)	(0.4)%	207	5.4 %
Commercial Risk-Based	4,777	4,765	4,479	12	0.3 %	286	6.4 %
BlueCard®	6,462	6,178	6,059	284	4.6 %	119	2.0 %
Employer Group Fee-Based	20,174	19,395	19,551	779	4.0 %	(156)	(0.8)%
Commercial Fee-Based	26,636	25,573	25,610	1,063	4.2 %	(37)	(0.1)%
Medicare Advantage	1,977	1,859	1,428	118	6.3 %	431	30.2 %
Medicare Supplement	947	952	933	(5)	(0.5)%	19	2.0 %
Total Medicare	2,924	2,811	2,361	113	4.0 %	450	19.1 %
Medicaid	11,571	10,600	8,852	971	9.2 %	1,748	19.7 %
Federal Employees Health Benefits	1,623	1,625	1,623	(2)	(0.1)%	2	0.1 %
Total Medical Membership	47,531	45,374	42,925	2,157	4.8 %	2,449	5.7 %
Other Membership							
Life and Disability Members	4,834	4,782	5,064	52	1.1 %	(282)	(5.6)%
Dental Members	6,692	6,674	6,385	18	0.3 %	289	4.5 %
Dental Administration Members	1,586	1,491	1,316	95	6.4 %	175	13.3 %
Vision Members	9,813	8,031	7,536	1,782	22.2 %	495	6.6 %
Medicare Part D Standalone Members	271	438	413	(167)	(38.1)%	25	6.1 %

December 31, 2022 Compared to December 31, 2021

Medical Membership

Total medical membership increased primarily due to organic growth, primarily driven by the continued temporary suspension of Medicaid eligibility recertification during the COVID-19 pandemic. In addition, Medicaid membership was positively impacted by the acquisition of Ohio Medicaid members through the purchase of a Medicaid contract in the first quarter of 2022 and the acquisition of Integra in the second quarter of 2022. Medicare Advantage organic growth due to sales exceeding lapses also contributed to the overall growth. Our Employer Group fee-based membership increased due to sales exceeding lapses and positive in-group changes. BlueCard® membership increased due to membership activity at other BCBSA plans whose members reside in or travel to our licensed areas. Individual membership increased due to our Public Exchange expansion in 2022.

Other Membership

Our other membership can be impacted by changes in our medical membership, as our medical members often purchase our other products that are ancillary to our health business. Life and disability membership increased primarily due to new sales of disability products, partially offset by declines in our life membership. Dental membership increased primarily due to new sales in our Employer Group risk-based accounts and penetration increases in our FEHB program, partially offset by the loss of a significant Employer Group fee-based account. Dental administration membership increased primarily due to increased sales to other BCBS plans associated with the FEHB program. Vision membership increased primarily due to the launch of a new entry-level vision product in our Employer Group markets. Medicare Part D Standalone membership declined as we discontinued certain legacy products.

Consolidated Results of Operations

Our consolidated summarized results of operations and other information for the years ended December 31, 2022, 2021 and 2020 are as follows:

	Years Ended December 31			Change			
				2022 vs. 2021		2021 vs. 2020	
	2022	2021	2020	$	%	$	%
Total operating revenue	$ 155,660	$ 136,943	$ 120,808	$ 18,717	13.7 %	$ 16,135	13.4 %
Net investment income	1,485	1,378	877	107	7.8 %	501	57.1 %
Net (losses) gains on financial instruments	(550)	318	182	(868)	NM	136	74.7 %
Total revenues	156,595	138,639	121,867	17,956	13.0 %	16,772	13.8 %
Benefit expense	116,642	102,571	88,045	14,071	13.7 %	14,526	16.5 %
Cost of products sold	13,035	10,895	8,953	2,140	19.6 %	1,942	21.7 %
Operating expense	17,700	15,918	17,450	1,782	11.2 %	(1,532)	(8.8)%
Other expense[1]	1,618	1,260	1,181	358	28.4 %	79	6.7 %
Total expenses	148,995	130,644	115,629	18,351	14.0 %	15,015	13.0 %
Income before income tax expense	7,600	7,995	6,238	(395)	(4.9)%	1,757	28.2 %
Income tax expense	1,712	1,846	1,666	(134)	(7.3)%	180	10.8 %
Net income	5,888	6,149	4,572	(261)	(4.2)%	1,577	34.5 %
Net loss attributable to noncontrolling interests	6	9	—	(3)	(33.3)%	9	— %
Shareholders' net income	$ 5,894	$ 6,158	$ 4,572	$ (264)	(4.3)%	$ 1,586	34.7 %
Average diluted shares outstanding	242.8	246.8	254.3	(4.0)	(1.6)%	(7.5)	(2.9)%
Diluted shareholders' net income per share	$ 24.28	$ 24.95	$ 17.98	$ (0.67)	(2.7)%	$ 6.97	38.8 %
Effective tax rate	22.5 %	23.1 %	26.7 %		(60)bp[3]		(360)bp[3]
Benefit expense ratio[2]	87.6 %	87.4 %	84.6 %		20bp[3]		280bp[3]
Operating expense ratio[4]	11.4 %	11.6 %	14.4 %		(20)bp[3]		(280)bp[3]
Income before income tax expense as a percentage of total revenues	4.9 %	5.8 %	5.1 %		(90)bp[3]		70bp[3]
Shareholders' net income as a percentage of total revenues	3.8 %	4.4 %	3.8 %		(60)bp[3]		60bp[3]

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

NM Not meaningful.

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

2 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2022, 2021 and 2020 were $133,229, $117,373 and $104,109, respectively. Premiums are included in total operating revenue presented above.

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

4 Operating expense ratio represents operating expense as a percentage of total operating revenue.

Year Ended December 31, 2022 Compared to the Year Ended December 31, 2021

Total operating revenue increased primarily as a result of higher premium revenue in our Medicaid business due to organic membership growth from the continued temporary suspension of Medicaid eligibility recertification during the COVID-19 pandemic, the acquisition of Integra in the second quarter of 2022 and the acquisition of Ohio Medicaid members through the purchase of a Medicaid contract in the first quarter of 2022. Membership growth in our Medicare Advantage and our commercial risk-based businesses, as well as premium rate increases to cover medical cost trends also generated higher premium revenue. Finally, the increase in operating revenue was further attributable to increased pharmacy product revenue in our CarelonRx segment, resulting from growth in membership and higher script volume.

Net investment income increased primarily due to higher income from fixed maturity securities, partially offset by reduced investment income from alternative investments.

We had net losses on financial instruments in 2022, as compared to net gains in 2021, as a result of increased net losses on the sale of fixed maturity securities, reduced gains on the sale of equity securities and lower net gains on other invested assets. These losses were partially offset by lower mark-to-market losses on equity securities still held.

Benefit expense increased primarily due to healthcare costs associated with organic membership growth in our Medicaid and Medicare businesses and the acquisition of MMM in the second quarter of 2021. Membership growth and higher healthcare costs in our commercial risk-based business, the acquisition of Integra in the second quarter of 2022 and the acquisition of Ohio Medicaid members through the purchase of a Medicaid contract in the first quarter of 2022 also contributed to higher benefit expense.

Our benefit expense ratio increased slightly primarily due to impact of continued membership increases in our Medicaid business, partially offset by the realignment during 2022 of certain quality improvement costs, from benefit expenses to operating expenses, due to regulatory clarification.

Cost of products sold reflects the cost of pharmaceuticals dispensed by CarelonRx for our unaffiliated pharmacy customers. Cost of products sold increased as the corresponding pharmacy product revenues increased.

Operating expense increased primarily due to increased costs to support membership growth and from our acquisitions, partially offset by lower business optimization charges in 2022 as compared to 2021.

Our operating expense ratio decreased primarily due to operating revenue growth in 2022 and lower business optimization charges in 2022 as compared to 2021, partially offset by increased costs to support membership growth and the impact of the realignment of certain quality improvement costs described above.

Other expense increased primarily due to additional amortization of intangible assets related to recent acquisitions and the rebranding of our products. The amortization period of certain intangible assets was shortened to align with anticipated dates the new branding will take place. In addition, certain indefinite-lived intangible assets have been reclassified as definite-lived, and therefore, are now being amortized. For additional information regarding intangible asset amortization, see Note 10, “Goodwill and Other Intangible Assets” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Our effective income tax rate decreased primarily due to the impact of geographic changes in our mix of earnings in 2022.

Our shareholders' net income as a percentage of total revenues decreased in 2022 as compared to 2021 as a result of all the factors discussed above.

Reportable Segments Results of Operations

The following table presents a summary of our reportable segment financial information for the years ended December 31, 2022, 2021 and 2020:

	Years Ended December 31			Change			
				2022 vs. 2021		2021 vs. 2020	
	2022	2021	2020	$	%	$	%
Operating Revenue							
Health Benefits	$138,484	$121,728	$ 108,271	$ 16,756	13.8 %	$ 13,457	12.4 %
CarelonRx	28,526	25,431	21,911	3,095	12.2 %	3,520	16.1 %
Carelon Services	12,277	9,648	5,720	2,629	27.2 %	3,928	68.7 %
Corporate & Other	1,017	602	337	415	68.9 %	265	78.6 %
Eliminations	(24,644)	(20,466)	(15,431)	(4,178)	20.4 %	(5,035)	32.6 %
Total operating revenue	$155,660	$136,943	$ 120,808	$ 18,717	13.7 %	$ 16,135	13.4 %
Operating Gain (Loss)							
Health Benefits[1]	$ 6,061	$ 5,884	$ 5,125	$ 177	3.0 %	$ 759	14.8 %
CarelonRx[2]	1,868	1,684	1,361	184	10.9 %	323	23.7 %
Carelon Services[3]	455	118	28	337	285.6 %	90	321.4 %
Corporate & Other[4]	(101)	(127)	(154)	26	NM	27	NM
Operating Margin							
Health Benefits	4.4 %	4.8 %	4.7 %		(40) bp[5]		10 bp[5]
CarelonRx	6.5 %	6.6 %	6.2 %		(10) bp[5]		40 bp[5]
Carelon Services	3.7 %	1.2 %	0.5 %		250 bp[5]		70 bp[5]

NM Not meaningful.

1 Includes expenses of $36 for business optimization initiatives in 2022; $153 for business optimization initiatives in 2021; $516 for business optimization initiatives and $548 for the BCBSA Litigation in 2020.
2 Includes expenses of $1 for business optimization initiatives in 2021 and $4 for business optimization initiatives in 2020.
3 Includes expenses of $5 for business optimization initiatives in 2022; $33 for business optimization initiatives in 2021 and $126 for business optimization initiatives in 2020.
4 Includes (credit) expense of $(2) for business optimization initiatives in 2022 and $11 for business optimization initiatives in 2020.
5 bp = basis point; one hundred basis points = 1%.

Year Ended December 31, 2022 Compared to the Year Ended December 31, 2021

Health Benefits

Operating revenue increased primarily due to higher premium revenue in our Medicaid business, including due to organic membership growth from the continued temporary suspension of Medicaid eligibility recertification during the COVID-19 pandemic, the acquisition of MMM at the end of the second quarter of 2021, the acquisition of Integra during the second quarter of 2022 and the acquisition of Ohio Medicaid members through the purchase of a Medicaid contract in the first quarter of 2022. Membership growth and premium rate increases to cover medical cost trends in our Medicare Advantage business and commercial risk-based business also contributed to higher premium revenue.

The increase in operating gain was primarily driven by premium rate increases to cover medical cost trends in our Medicare business, organic membership growth in our Medicaid business from the continued suspension of eligibility recertifications during the COVID-19 pandemic and the acquisition of MMM in the second quarter of 2021. The increase in operating gain was also due to improved medical underwriting performance in our commercial risk-based business and reduced business optimization charges within the Health Benefits segment in 2022 as compared to 2021.These increases were partially offset by additional administrative spend to support membership growth.

CarelonRx

Operating revenue increased as a result of growth in membership and higher script volume.

The increase in operating gain was primarily a result of higher script volume, driven by growth in integrated medical and pharmacy members in 2022 and favorable out-of-period adjustments to fee-based revenue in the second half of 2022.

Carelon Services

Operating revenue increased primarily due to higher revenue for expanded services performed by Carelon Services for our Health Benefits segment in 2022 and the acquisition of myNEXUS in the second quarter of 2021. These increases were partially offset by the reduction of external revenue due to the loss of a behavioral health contract in 2022.

The increase in operating gain was driven by overall improved performance and the acquisition of myNEXUS in the second quarter of 2021.

Corporate & Other

Operating revenue increased primarily due to higher affiliated revenues in our international operations.

The decrease in operating loss was primarily due to a decline in unallocated corporate expenses in 2022.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our other significant accounting policies are summarized in Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third-party professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances. Estimates can require a significant amount of judgment, and a different set of assumptions could result in material changes to our reported results.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2022, this liability was $15,596 and represented 23% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 94%, or $14,736, of our total medical claims liability as of December 31, 2022; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 6%, or $860, of the total medical claims payable as of December 31, 2022. The level of claims payable processed through our systems but not yet paid may fluctuate from one period-end to the next, from approximately 1% to 6% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Our reserving practice for claim liabilities is to consistently recognize the appropriate amount of reserve within a level of confidence required by Actuarial Standards of Practice. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims

data is formatted into “claim triangles,” which compare claim incurred dates to the dates of claim payments. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels (“trend factors”).

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison to prior periods, the methods and assumptions are not changed as reserves are recalculated; rather, the availability of additional paid claims information drives changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense. We had increased estimation uncertainty on our incurred but not reported liability at December 31, 2022 and December 31, 2021. Slowdowns in claims submission patterns and increases in utilization levels for COVID-19 testing and treatment are the primary factors that lead to the increased estimation uncertainty.

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

Although there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2022 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2022, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower estimated variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions results in variability of 2%, or approximately $266, in the December 31, 2022 incurred but not paid claims liability, depending on the completion factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period.

However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2022 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2022, there was a 310 basis point differential in the high and low trend factors. This range of trend factors would imply variability of 3%, or approximately $522, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2022. The COVID-19 pandemic continues to have an impact on claim costs for recent dates of service, which could have an influence on our trend factors. We will continue to monitor emerging experience in order to better understand the possible implications to our reserves.

See Note 12, “Medical Claims Payable,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2022, 2021 and 2020. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 12, “Medical Claims Payable,” the line labeled “Net incurred medical claims: Prior years redundancies” accounts for those adjustments made to prior year estimates. The impact of any reduction of “Net incurred medical claims: Prior years redundancies” may be offset as we establish the estimate of “Net incurred medical claims: Current year.” Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 87.3% for 2022, 87.8% for 2021 and 87.7% for 2020. This ratio serves as an indicator of claims processing speed whereby 2022 claims were processed at a slightly slower speed than 2021 and 2020.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred claims payable less prior year redundancies in the current year in order to demonstrate the development of the prior year reserves. For the year ended December 31, 2022, this metric was 7.0%, largely driven by favorable trend factor development at the end of 2021. For the year ended December 31, 2021, this metric was 18.1%, reflecting the estimation uncertainty due to COVID-19 at the end of 2020, and was largely driven by favorable trend factor development at the end of 2020 as well as favorable completion factor development from 2020. For the year ended December 31, 2020, this metric was 8.0%, largely driven by favorable trend factor development at the end of 2019 as well as favorable completion factor development from 2019.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the year ended December 31, 2022, this metric was 0.9%, which was calculated using the redundancy of $869. This metric was 2.0% for 2021 and 0.8% for 2020. We believe these metrics support the reasonableness of our estimates. The 2021 metric was impacted by the estimation uncertainty due to COVID-19.

The following table shows the variance between total net incurred medical claims as reported in Note 12, “Medical Claims Payable,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1, for each of 2021 and 2020 and the incurred claims for such years had it been determined retrospectively (computed as the difference

between “net incurred medical claims – current year” for the year shown and “net incurred medical claims – prior years redundancies” for the immediately following year):

	Years Ended December 31	
	2021	2020
Total net incurred medical claims, as reported	$ 98,737	$ 84,457
Retrospective basis, as described above	99,571	83,391
Variance	$ (834)	$ 1,066
Variance to total net incurred medical claims, as reported	(0.8)%	1.3 %

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2022 estimate of medical claims payable will be known during 2023.

The 2021 variance to total net incurred medical claims, as reported of (0.8)% was less than the 2020 percentage of 1.3%. This was primarily driven by the fact that the change in the prior year redundancy reported for 2021 as compared to 2020 was less than the change in the prior year redundancy reported for 2020 as compared to 2019.

Income Taxes

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

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

- the types of temporary differences that created the deferred tax asset;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the tax rate at which the deferred tax assets will likely be utilized in the future;
- the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item;
- the implementation of tax planning strategies to recover those deferred tax assets; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

Although realization is not assured, we believe it is more likely than not that the deferred tax assets will be realized.

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

In the ordinary course of business, we are regularly audited by federal and other tax authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law, and we intend to defend our positions vigorously through the federal, state and local, and foreign appeals processes. We believe we have

adequately provided for any reasonably foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact on our results of operations or financial condition from these matters.

For additional information, see Note 8, "Income Taxes," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2022 was $24,383 and other intangible assets were $10,315. The sum of goodwill and other intangible assets represented 33.8% of our total consolidated assets and 95.7% of our consolidated shareholders' equity at December 31, 2022.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. We have the option of first performing a qualitative assessment for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, which is an indication that our goodwill may be impaired. These qualitative impairment tests include assessing events and factors that could affect the fair value of the indefinite-lived intangible assets. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. If we determine that a reporting unit's goodwill may be impaired after utilizing these qualitative impairment analysis procedures, we are required to perform a quantitative impairment test.

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

We did not incur any impairment losses as a result of our 2022 annual impairment tests, as it was determined that it is more likely than not that the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2022. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months.

If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, "Business Acquisitions" and Note 10, "Goodwill and Other Intangible Assets" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Investments

Current and long-term marketable investment securities were $27,657 at December 31, 2022 and represented 26.9% of our total consolidated assets at December 31, 2022. We classify fixed maturity securities in our investment portfolio as "available-for-sale" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

Our impairment review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors. Such factors considered include the extent to which a security's market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends.

If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, we write down the fixed maturity security's cost basis to fair value and record an impairment loss in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or if it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, we recognize the credit component of the impairment as an allowance for credit loss in our consolidated balance sheets and record an impairment loss in our consolidated statements of income. The non-credit component of the impairment is recognized in accumulated other comprehensive (loss) income. Furthermore, unrealized losses entirely caused by non-credit-related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive (loss) income.

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

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. We believe that we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. We have established an allowance for credit loss and recorded credit loss expense as a reflection of our expected impairment losses. Given the inherent uncertainty of changes in market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and additional impairment losses on investments may be recorded in future periods.

In addition to marketable investment securities, we held additional long-term investments of $5,685, or 5.5% of total consolidated assets, at December 31, 2022. These long-term investments consisted primarily of certain other equity investments, the cash surrender value of corporate-owned life insurance policies and mortgage loans. Due to their less liquid nature, these investments are classified as long-term.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future results of operations and financial condition. Our investment portfolio includes fixed maturity securities with a fair value of $26,704 at December 31, 2022. The weighted-average credit rating of these securities was "A" as of December 31, 2022. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions of $890 that are guaranteed by third parties. With the exception of 16 securities with a fair value of $9,

these securities are all investment-grade and carry a weighted-average credit rating of "AA" as of December 31, 2022. The securities are guaranteed by a number of different guarantors, and we do not have any material exposure to any single guarantor, neither indirectly through the guarantees, nor directly through investment in the guarantor. Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of the fixed maturity securities without a guarantee, for which such information is available, was "A" as of December 31, 2022.

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

We obtain quoted market prices for each security from the pricing services, which are derived through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in these valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2022 and 2021.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2022 totaled $581 and represented approximately 1.7% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities and equity securities for which observable inputs were not always available and the fair values of these securities were estimated using inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A, "Quantitative and Qualitative Disclosures about Market Risk" included in our 2022 Form 10-K and Note 2, "Basis of Presentation and Significant Accounting Policies," Note 5, "Investments," and Note 7, "Fair Value" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Retirement Benefits

Pension Benefits

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

An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our December 31, 2022 measurement date, we selected a weighted-average long-term rate of return on plan assets of 6.58%. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and an average of historical returns are also reviewed for appropriateness of the selected assumption. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

This assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is

included in the determination of pension expense. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. We use the annual spot rate approach for setting our discount rate. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan's cash flows to determine the plan's obligation. At the December 31, 2022 measurement date, the weighted-average discount rate under the annual spot rate approach was 5.18%, compared to 2.70% at the December 31, 2021 measurement date. The net effect of changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FASB guidance.

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

Other Postretirement Benefits

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

At our December 31, 2022 measurement date, the selected discount rate for all plans was 5.12%, compared to a discount rate of 2.49% at the December 31, 2021 measurement rate. We developed this rate using the annual spot rate approach as described above.

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2022 measurement date was 8.00% for 2023 with a gradual decline to 4.50% by the year 2035. The assumed healthcare cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2022 measurement date was 6.50% for 2023 with a gradual decline to 4.50% by the year 2035. These estimated trend rates are subject to change in the future.

For additional information regarding our retirement benefits, see Note 11, "Retirement Benefits" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2022 that had, or are expected to have, a material impact on our financial position, results of operations or financial statement disclosures, see the "*Recently Adopted Accounting Guidance*" section of Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Liquidity and Capital Resources

Introduction

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

timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

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

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

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have in the past experienced higher than normal volatility. Interest rates on fixed debt income securities increased in 2022 and may continue to do so in 2023, which could increase our borrowing costs if we elect to issue debt. During recent years, the federal government and various governmental agencies have taken a number of steps to strengthen the regulation of the financial services market. In addition, governments around the world have developed their own plans to provide stability and security in the credit markets and to ensure adequate capital in certain financial institutions.

A summary of our major sources and uses of cash and cash equivalents for the years ended December 31, 2022, 2021 and 2020 is as follows:

	Years Ended December 31			$ Change	
	2022	2021	2020	2022 vs. 2021	2021 vs. 2020
Sources of Cash:					
Net cash provided by operating activities	$ 8,399	$ 8,364	$ 10,688	$ 35	$ (2,324)
Issuances of commercial paper and short- and long-term debt, net of repayments	862	2,719	—	(1,857)	2,719
Issuances of common stock under employee stock plans	182	203	176	(21)	27
Other sources of cash, net	762	—	315	762	(315)
Total sources of cash	10,205	11,286	11,179	(1,081)	107
Uses of Cash:					
Purchases of investments, net of proceeds from sales, maturities, calls and redemptions	(2,338)	(4,056)	(3,433)	1,718	(623)
Repurchase and retirement of common stock	(2,316)	(1,900)	(2,700)	(416)	800
Purchases of subsidiaries, net of cash acquired	(649)	(3,476)	(1,976)	2,827	(1,500)
Purchases of property and equipment	(1,152)	(1,087)	(1,021)	(65)	(66)
Repayments of commercial paper and short- and long-term debt, net of issuances	—	—	(298)	—	298
Cash dividends	(1,229)	(1,104)	(954)	(125)	(150)
Other uses of cash, net	—	(514)	—	514	(514)
Total uses of cash	(7,684)	(12,137)	(10,382)	4,453	(1,755)
Effect of foreign exchange rates on cash and cash equivalents	(14)	(10)	7	(4)	(17)
Net increase (decrease) in cash and cash equivalents	$ 2,507	$ (861)	$ 804	$ 3,368	$ (1,665)

Liquidity—Year Ended December 31, 2022 Compared to Year Ended December 31, 2021

The slight increase in cash provided by operating activities was primarily due to higher net income in 2022, when adjusted for the impact of investment losses and gains, partially offset by the timing of working capital changes and the payment pursuant to the Subscriber Settlement Agreement made in September 2022.

Other significant changes in sources and uses of cash year-over-year included lower amounts used for purchases of subsidiaries, net of cash acquired and reduced cash used for purchases of investments, net of proceeds from sales, maturities, calls and redemptions. These decreased uses of cash were partially offset by reduced net proceeds received from the issuance of commercial paper and short-term and long-term debt and increased use of cash for share repurchases.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments in fixed maturity and equity securities of $35,044.0 at December 31, 2022. Since December 31, 2021, total cash, cash equivalents and investments in fixed maturity and equity securities increased by $1,384, primarily due to cash generated from operations. This increase was partially offset by cash used for acquisitions, common stock repurchases, purchases of property and equipment and cash dividends paid to shareholders.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, or other regulatory requirements, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2022, we held $1,209 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Periodically, we access capital markets and issue debt ("Notes") for long-term borrowing purposes, for example, to refinance debt, to finance acquisitions or for share repurchases. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating. For more information on our debt, including redemptions and issuances, see Note 13, "Debt" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our audited consolidated balance sheets included in Part II, Item 8 of this Exhibit 99.1. Our debt-to-capital ratio is calculated as total debt divided by total debt plus total shareholders' equity. Total debt is the sum of short-term borrowings, current portion of long-term debt and long-term debt, less current portion. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 39.9% and 38.9% as of December 31, 2022 and 2021, respectively.

Our senior debt is rated "A" by S&P Global Ratings, "BBB" by Fitch Ratings, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, liquidity, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Capital Resources

We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for

general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansions.

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. In April 2022, we amended and restated the credit agreement for the 5-Year Facility to, among other things, extend the maturity date of the 5-Year Facility from June 2024 to April 2027 and increase the amount of credit available under the 5-Year Facility from $2,500 to $4,000. Also in April 2022, concurrently with the amendment and restatement of the 5-Year Facility, we terminated our 364-day senior revolving credit facility that provided for credit in the amount of $1,000, which was scheduled to mature in June 2022. Our ability to borrow under the 5-Year Facility is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the credit agreement for the 5-Year Facility. We do not believe the restrictions contained in our 5-Year Facility covenants materially affect our financial or operating flexibility. As of December 31, 2022, we were in compliance with all of our debt covenants under the 5-Year Facility. There were no amounts outstanding under the 5-Year Facility at December 31, 2022.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit (the "Subsidiary Credit Facilities") with separate lenders for general corporate purposes. The Subsidiary Credit Facilities provide combined credit up to $200. Our ability to borrow under the Subsidiary Credit Facilities is subject to compliance with certain covenants. At December 31, 2022, we had no outstanding borrowings under the Subsidiary Credit Facilities.

We have an authorized commercial paper program of up to $4,000, the proceeds of which may be used for general corporate purposes. In July 2022, we increased the amount available under the commercial paper program from $3,500 to $4,000. Should commercial paper issuance become unavailable, we have the ability to use a combination of cash on hand and/or our 5-Year Facility, which provides for credit in the amount of $4,000, to redeem any outstanding commercial paper upon maturity. At December 31, 2022, we had $0 outstanding under our commercial paper program.

While there is no assurance in the current economic environment, we believe the lenders participating in our 5-Year Facility and Subsidiary Credit Facilities, if market conditions allow, would be willing to provide financing in accordance with their legal obligations.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York (collectively the "FHLBs"). As a member, we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2022, we had $265 of outstanding short-term borrowings from the FHLBs.

As discussed in "*Financial Condition*" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we currently estimate that approximately $3,500 of dividends will be paid to us by our subsidiaries during 2023. During 2022, we received $3,097 of dividends from our subsidiaries.

In addition to regulations regarding the timing and amount of dividends, our regulated subsidiaries' states of domicile have statutory risk-based capital ("RBC") requirements for health and other insurance companies and health maintenance organizations largely based on the National Association of Insurance Commissioners ("NAIC") Risk-Based Capital (RBC) For Health Organizations Model Act ("RBC Model Act"). These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer's investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries' respective RBC levels as of December 31, 2022, which was the most recent date for which reporting was required, were in excess of all applicable mandatory RBC requirements. In addition to exceeding these RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries. For additional information, see Note 22, "Statutory Information" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.

Future Sources and Uses of Liquidity

Short-Term Liquidity Requirements

As previously described, our cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. We believe cash on hand, operating cash receipts, investments and amounts available under our commercial paper program, our 5-Year Facility and our Subsidiary Credit Facilities and borrowings available from the FHLBs will be adequate to fund our expected cash disbursements over the next twelve months.

Long-Term Liquidity Requirements

As of December 31, 2022, our long-term cash disbursements required under various contractual obligations and commitments were:

- *Debt and interest expense:* Future debt and estimated interest payments were $25,804, with $2,674 due within the next twelve months. For additional information, see Note 13 "Debt" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.
- *Operating leases:* We lease office space and certain computer equipment, for which the future estimated payments were $1,028, with $206 due within the next twelve months. For additional information, see Note 18 "Leases" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.
- *Other liabilities:* These liabilities primarily consist of future policy reserves, projected other postretirement benefits, deferred compensation, supplemental executive retirement plan liabilities and certain other miscellaneous long-term obligations. Amounts due within twelve months were $26, with $1,040 due in future periods. Estimated future payments for funded pension benefits have been excluded from these numbers, as we had no funding requirements under the Employee Retirement Income Security Act of 1974, as amended, at December 31, 2022, as a result of the value of the assets in the plans. In addition, gross liabilities for uncertain tax positions and interest for which we cannot reasonably estimate the timing of the resolutions with the respective taxing authorities have not been included. For further information, see Note 8, "Income Taxes" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.
- *Purchase obligations:* These obligations include estimated payments for future services under contractual arrangements from third-party service vendors. Amounts due within the next twelve months for these purchase obligations were $1,124, while longer term payments were $2,927. For further information, see Note 14, "Commitments and Contingencies" of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Exhibit 99.1.
- *Investment commitments:* These include unfunded capital commitments for alternative investments and low-income housing tax credits. Estimated amounts due were $1,504, including $314 due within the next twelve months.

In addition to the contractual obligations and commitments discussed above, we have a variety of other contractual agreements related to acquiring materials and services used in our operations. However, we do not believe these other agreements contain material noncancelable commitments.

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

On January 24, 2023, our Audit Committee declared a quarterly cash dividend to shareholders of $1.48 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 24, 2023 to the shareholders of record as of March 10, 2023.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. As of December 31, 2022, we had Board authorization of $1,876 to repurchase our common stock. On January 24, 2023, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized a $5,000 increase to our common stock repurchase

program. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time. We intend to utilize this authorization over a multi-year period, subject to market and industry conditions.

We believe that funds from future operating cash flows, cash and investments and funds available under our credit facilities and/or from public or private financing sources will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

We do not have any off-balance sheet derivative instruments, guarantee transactions, agreements or other contractual arrangements or any indemnification agreements that will require funding in future periods. We have not transferred assets to an unconsolidated entity that serves as credit, liquidity or market risk support to such entity. We do not hold any variable interest in an unconsolidated entity where such entity provides us with financing, liquidity, market risk or credit risk support. See Note 2 “Subsidiary Transactions” of the Notes to Condensed Financial Statements included in Part IV, Item 15 of this Exhibit 99.1 for additional detail on the Elevance Health, Inc. parent guarantees of certain subsidiaries.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

Elevance Health, Inc.

CONSOLIDATED FINANCIAL STATEMENTS

Years ended December 31, 2022, 2021 and 2020

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Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Elevance Health, Inc.

Opinion on Internal Control Over Financial Reporting

We have audited Elevance Health, Inc.'s internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control–Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Elevance Health, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2022, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Elevance Health, Inc. as of December 31, 2022 and 2021, the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2022, and the related notes and financial statement schedule listed in the Index at Item 15(c) and our report dated February 15, 2023 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

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

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

/s/ Ernst & Young LLP

Indianapolis, Indiana
February 15, 2023

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Elevance Health, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Elevance Health, Inc. (the Company) as of December 31, 2022 and 2021, the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2022, and the related notes and financial statement schedule listed in the Index at Item 15(c) (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2022 and 2021, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2022, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 15, 2023 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the account or disclosures to which it relates.

Valuation of Incurred but Not Paid Claims

Description of the Matter	Medical claims payable was $15,596 million at December 31, 2022, a significant portion of which related to the Company's estimate for claims that are incurred but not paid. As discussed in Note 2 to the consolidated financial statements, the Company's liability for incurred but not paid claims is determined using actuarial methods that include a number of factors and assumptions, including completion factors, which represent the average percentage of total incurred claims that have been paid through a given date after being incurred based on historical paid claims data, and trend factors, which represent an estimate of claims expense based on recent claims expense levels and healthcare cost levels. There is significant uncertainty inherent in determining management's best estimate of completion and trend factors, which are used to calculate actuarial estimates of incurred but not paid claims. Auditing management's estimate of incurred but not paid claims was complex and required the involvement of our actuarial specialists due to the highly judgmental nature of the completion and trend factor assumptions used in the valuation process. The significant judgment was primarily due to the sensitivity of management's best estimate of completion and trend factor assumptions, which have a significant impact on the valuation of incurred but not paid claims.
How We Addressed the Matter in Our Audit	We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's actuarial process for estimating the liability for incurred but not paid claims. These audit procedures included among others, testing management review controls over completion and trend factor assumptions and the review and approval processes that management has in place for estimating the liability for incurred but not paid claims. To test the Company's liability for incurred but not paid claims, our audit procedures included, among others, testing the completeness and accuracy of the underlying claims and membership data recorded in the source claims processing and disbursement systems to the data used by management in developing completion and trend factor assumptions and agreeing a sample of incurred and paid claims to source documentation. With the support of actuarial specialists, we analyzed the Company's completion and trend factor assumptions based on historical claim experience and emerging cost trends, and independently calculated a range of reasonable reserve estimates for comparison to management's best estimate of the liability for incurred but not paid claims. Additionally, we performed a review of the prior period liabilities for incurred but not paid claims to subsequent claims development.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 1944.

Indianapolis, Indiana
February 15, 2023, except for Note 2 and Note 20, as to which the date is October 18, 2023

Elevance Health, Inc.
Consolidated Balance Sheets

(In millions, except share data)	December 31, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 7,387	$ 4,880
Fixed maturity securities (amortized cost of $28,226 and $25,641; allowance for credit losses of $9 and $6)	25,952	26,267
Equity securities	953	1,881
Premium receivables	7,083	5,681
Self-funded receivables	4,663	4,010
Other receivables	4,298	3,749
Other current assets	5,281	4,654
Total current assets	55,617	51,122
Long-term investments:		
Fixed maturity securities (amortized cost of $789 and $616; allowance for credit losses of $0 and $0)	752	632
Other invested assets	5,685	5,225
Property and equipment, net	4,316	3,919
Goodwill	24,383	24,228
Other intangible assets	10,315	10,615
Other noncurrent assets	1,687	1,715
Total assets	$ 102,755	$ 97,456
Liabilities and equity		
Liabilities		
Current liabilities:		
Medical claims payable	$ 15,596	$ 13,518
Other policyholder liabilities	5,933	5,521
Unearned income	1,112	1,153
Accounts payable and accrued expenses	5,607	4,970
Short-term borrowings	265	275
Current portion of long-term debt	1,500	1,599
Other current liabilities	9,683	7,849
Total current liabilities	39,696	34,885
Long-term debt, less current portion	22,349	21,157
Reserves for future policy benefits	803	753
Deferred tax liabilities, net	2,015	2,815
Other noncurrent liabilities	1,562	1,683
Total liabilities	66,425	61,293
Commitments and Contingencies—Note 14		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 237,958,067 and 241,770,746	2	2
Additional paid-in capital	9,084	9,148
Retained earnings	29,647	27,142
Accumulated other comprehensive loss	(2,490)	(197)
Total shareholders' equity	36,243	36,095
Noncontrolling interests	87	68
Total equity	36,330	36,163
Total liabilities and equity	$ 102,755	$ 97,456

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Income

(In millions, except per share data)	Years Ended December 31 2022	2021	2020
Revenues			
Premiums	$ 133,229	$ 117,373	$ 104,109
Product revenue	14,978	12,657	10,384
Service fees	7,453	6,913	6,315
Total operating revenue	155,660	136,943	120,808
Net investment income	1,485	1,378	877
Net (losses) gains on financial instruments	(550)	318	182
Total revenues	156,595	138,639	121,867
Expenses			
Benefit expense	116,642	102,571	88,045
Cost of products sold	13,035	10,895	8,953
Operating expense	17,700	15,918	17,450
Interest expense	851	798	784
Amortization of other intangible assets	767	441	361
Loss on extinguishment of debt	—	21	36
Total expenses	148,995	130,644	115,629
Income before income tax expense	7,600	7,995	6,238
Income tax expense	1,712	1,846	1,666
Net income	5,888	6,149	4,572
Net loss attributable to noncontrolling interests	6	9	—
Shareholders' net income	$ 5,894	$ 6,158	$ 4,572
Shareholders' net income per share			
Basic	$ 24.56	$ 25.26	$ 18.23
Diluted	$ 24.28	$ 24.95	$ 17.98
Dividends per share	$ 5.12	$ 4.52	$ 3.80

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Comprehensive Income

(In millions)	Years Ended December 31 2022	2021	2020
Net income	$ 5,888	$ 6,149	$ 4,572
Other comprehensive (loss) income, net of tax:			
Change in net unrealized gains/losses on investments	(2,260)	(457)	428
Change in non-credit component of impairment losses on investments	(3)	2	—
Change in net unrealized gains/losses on cash flow hedges	10	11	12
Change in net periodic pension and postretirement costs	(70)	123	(1)
Change in future policy benefits	32	(7)	—
Foreign currency translation adjustments	(13)	(9)	7
Other comprehensive (loss) income	(2,304)	(337)	446
Net loss attributable to noncontrolling interests	6	9	—
Other comprehensive loss attributable to noncontrolling interests	11	2	—
Total shareholders' comprehensive income	$ 3,601	$ 5,823	$ 5,018

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Cash Flows

(In millions)	Years Ended December 31 2022	2021	2020
Operating activities			
Net income	$ 5,888	$ 6,149	$ 4,572
Adjustments to reconcile net income to net cash provided by operating activities:			
Net losses (gains) on financial instruments	550	(318)	(182)
Equity in net earnings of other invested assets	(293)	(562)	(51)
Depreciation and amortization	1,675	1,302	1,154
Deferred income taxes	(115)	342	(540)
Impairment of property and equipment	7	73	198
Share-based compensation	264	255	283
Changes in operating assets and liabilities:			
Receivables, net	(2,510)	(2,138)	(256)
Other invested assets	11	(70)	(32)
Other assets	133	41	(283)
Policy liabilities	2,411	2,523	3,528
Unearned income	(42)	(113)	202
Accounts payable and other liabilities	824	719	1,978
Income taxes	(338)	140	72
Other, net	(66)	21	45
Net cash provided by operating activities	8,399	8,364	10,688
Investing activities			
Purchases of investments	(24,946)	(18,669)	(19,492)
Proceeds from sale of investments	11,988	10,269	11,318
Maturities, calls and redemptions from investments	10,620	4,344	4,741
Changes in securities lending collateral	(301)	(956)	(849)
Purchases of subsidiaries, net of cash acquired	(649)	(3,476)	(1,976)
Purchases of property and equipment	(1,152)	(1,087)	(1,021)
Other, net	(120)	(63)	(45)
Net cash used in investing activities	(4,560)	(9,638)	(7,324)
Financing activities			
Net (repayments of) proceeds from commercial paper borrowings	(300)	50	(150)
Proceeds from long-term borrowings	3,071	3,462	2,484
Repayments of long-term borrowings	(1,899)	(1,068)	(1,932)
Proceeds from short-term borrowings	1,365	1,325	970
Repayments of short-term borrowings	(1,375)	(1,050)	(1,670)
Changes in securities lending payable	302	956	849
Changes in bank overdrafts	933	(376)	486
Repurchase and retirement of common stock	(2,316)	(1,900)	(2,700)
Cash dividends	(1,229)	(1,104)	(954)
Proceeds from issuance of common stock under employee stock plans	182	203	176
Taxes paid through withholding of common stock under employee stock plans	(93)	(102)	(128)
Other, net	41	27	2
Net cash (used in) provided by financing activities	(1,318)	423	(2,567)
Effect of foreign exchange rates on cash and cash equivalents	(14)	(10)	7
Change in cash and cash equivalents	2,507	(861)	804
Cash and cash equivalents at beginning of year	4,880	5,741	4,937
Cash and cash equivalents at end of year	$ 7,387	$ 4,880	$ 5,741

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Shareholders' Equity

(In millions)	Total Shareholders' Equity						
	Common Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income	Noncontrolling Interests	Total Equity
	Number of Shares	Par Value					
January 1, 2020	252.9	$ 3	$ 9,448	$ 22,538	$ (296)	$ —	$ 31,693
Net income	—	—	—	4,572	—	—	4,572
Other comprehensive income	—	—	—	—	446	—	446
Repurchase and retirement of common stock	(9.4)	—	(353)	(2,347)	—	—	(2,700)
Dividends and dividend equivalents	—	—	—	(961)	—	—	(961)
Issuance of common stock under employee stock plans, net of related tax benefits	1.9	—	330	—	—	—	330
Convertible debenture repurchases and conversions	—	—	(181)	—	—	—	(181)
December 31, 2020	245.4	3	9,244	23,802	150	—	33,199
Adoption of Accounting Standards Update 2018-12 (Note 2)	—	—	—	—	(12)	—	(12)
January 1, 2021	245.4	3	9,244	23,802	138	—	33,187
Net income	—	—	—	6,158	—	(9)	6,149
Other comprehensive loss	—	—	—	—	(335)	(2)	(337)
Accumulated noncontrolling interest	—	—	—	—	—	79	79
Repurchase and retirement of common stock	(5.1)	(1)	(192)	(1,707)	—	—	(1,900)
Dividends and dividend equivalents	—	—	—	(1,111)	—	—	(1,111)
Issuance of common stock under employee stock plans, net of related tax benefits	1.5	—	355	—	—	—	355
Convertible debenture repurchases and conversions	—	—	(259)	—	—	—	(259)
December 31, 2021	241.8	2	9,148	27,142	(197)	68	36,163
Adoption of Accounting Standards Update 2020-06 (Note 2)	—	—	—	(23)	—	—	(23)
January 1, 2022	241.8	2	9,148	27,119	(197)	68	36,140
Net income	—	—	—	5,894	—	(6)	5,888
Other comprehensive loss	—	—	—	—	(2,293)	(11)	(2,304)
Noncontrolling interests adjustment	—	—	—	—	—	36	36
Repurchase and retirement of common stock	(4.8)	—	(184)	(2,132)	—	—	(2,316)
Dividends and dividend equivalents	—	—	—	(1,234)	—	—	(1,234)
Issuance of common stock under employee stock plans, net of related tax benefits	1.0	—	352	—	—	—	352
Convertible debenture repurchases and conversions	—	—	(232)	—	—	—	(232)
December 31, 2022	238.0	$ 2	$ 9,084	$ 29,647	$ (2,490)	$ 87	$ 36,330

See accompanying notes.

Elevance Health, Inc.

Notes to Consolidated Financial Statements

December 31, 2022

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

1. Organization

On May 18, 2022, our shareholders approved a proposal to amend our amended and restated articles of incorporation to change our name from Anthem, Inc. to Elevance Health, Inc. This amendment and name change went into effect on June 27, 2022. We began operating as Elevance Health, Inc. and trading under our new ticker symbol "ELV" on June 28, 2022. References to the terms "we," "our," "us" or "Elevance Health" used throughout these Notes to Consolidated Financial Statements refer to Elevance Health, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia and Puerto Rico, unless the context otherwise requires.

Elevance Health is a health company with the purpose of improving the health of humanity. We are one of the largest health insurers in the United States in terms of medical membership, serving approximately 47.5 million medical members through our affiliated health plans as of December 31, 2022. 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 and 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 unaffiliated health plans, including pharmacy services and 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, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. Through our subsidiaries, we also serve customers in numerous states as Amerigroup, Freedom Health, HealthLink, HealthSun, MMM, Optimum Healthcare, Simply Healthcare, UniCare and/or Wellpoint. We offer pharmacy services as CarelonRx and other health-care related services as Carelon Services, Aspire Health, Carelon Behavioral Health and Caremore. We are licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through our subsidiaries.

As part of our name change to Elevance Health, in June 2022, we announced that over the next several years we will organize 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 formerly named Diversified Business Group and IngenioRx 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. As a result, we changed our reportable segments to the following beginning in the first

quarter of 2023: 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). For additional discussion, see Note 20, "Segment Information."

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements include the accounts of Elevance Health and its subsidiaries and have been prepared in conformity with U.S. generally accepted accounting principles ("GAAP"). All significant intercompany accounts and transactions have been eliminated in consolidation.

The accompanying consolidated financial statements and the notes to the consolidated financial statements have been recast and are presented as they would have appeared had we changed our reportable segments, discussed in Note 20, and adopted the new accounting standard, discussed in this Note 2 below, prior to January 1, 2023.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar ("USD"). We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in "Foreign currency translation adjustments" in our consolidated statements of comprehensive income.

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation.

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. Our most significant estimate relates to estimates and judgments for medical claims payable. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents includes available cash and all highly liquid investments with maturities of three months or less when purchased. We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits, and we have cash and cash equivalents on deposit to meet certain regulatory requirements. These amounts totaled $258 and $173 at December 31, 2022 and 2021, respectively, and are included in the cash and cash equivalents line on our consolidated balance sheets.

Investments: We classify fixed maturity securities in our investment portfolio as "available-for-sale" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, we write down the fixed maturity security's cost basis to fair value and record an impairment loss in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or if it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, we recognize the credit component of the impairment as an allowance for credit loss in our consolidated balance sheets and record an impairment loss in our consolidated statements of income. The non-credit component of the impairment is recognized in accumulated other comprehensive loss. Furthermore, unrealized losses entirely caused by non-credit-related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive loss.

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

probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the purchase date of the securities. Such adjustments are reported within net investment income.

The changes in fair value of our marketable equity securities are recognized in our results of operations within net gains and losses on financial instruments. Certain marketable equity securities are held to satisfy contractual obligations, and are reported under the caption “Other invested assets” in our consolidated balance sheets.

We have corporate-owned life insurance policies on certain participants in our deferred compensation plans and other members of management. The cash surrender value of the corporate-owned life insurance policies is reported under the caption “Other invested assets” in our consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest may enable us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported within net investment income. The equity method investments are reported under the caption “Other invested assets” in our consolidated balance sheets.

Investment income is recorded when earned. All securities sold resulting in investment realized gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. Under Financial Accounting Standards Board (“FASB”) guidance related to accounting for transfers and servicing of financial assets and extinguishments of liabilities, we recognize the collateral as an asset, which is reported in other current assets on our consolidated balance sheets, and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported in other current liabilities. The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive income as a separate component of shareholders’ equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities’ value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondarily, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Receivables: Receivables are reported net of amounts for expected credit losses. The allowance for doubtful accounts is based on historical collection trends, future forecasts and our judgment regarding the ability to collect specific accounts.

Premium receivables include the uncollected amounts from insured groups, individuals and government programs. Premium receivables are reported net of an allowance for doubtful accounts of $152 and $142 at December 31, 2022 and 2021, respectively.

Self-funded receivables include administrative fees, claims and other amounts due from fee-based customers. Self-funded receivables are reported net of an allowance for doubtful accounts of $68 and $50 at December 31, 2022 and 2021, respectively.

Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance receivables, proceeds due from brokers on investment trades, accrued investment income and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of $744 and $648 at December 31, 2022 and 2021, respectively.

Income Taxes: We file a consolidated U.S. federal income tax return. Deferred income tax assets and liabilities are recognized for temporary differences between the financial statement and tax return basis of assets and liabilities based on enacted tax rates and laws and are reported net on our consolidated balance sheets. The deferred tax benefits of the deferred tax assets are recognized to the extent realization of such benefits is more likely than not. Deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year, excluding the impact from amounts initially recorded for business combinations, if any, and amounts recorded to accumulated other comprehensive income. Current income tax expense represents the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

The Internal Revenue Code subjects a U.S. shareholder to tax on Global Intangible Low-Taxed Income ("GILTI") earned by certain foreign subsidiaries. We have elected to account for GILTI tax in the year the tax is incurred.

The Inflation Reduction Act of 2022 includes a provision that imposes a new corporate alternative minimum tax (the "Corporate AMT") that became effective for us beginning January 1, 2023. We have elected to account for the effects of the Corporate AMT on deferred tax assets and carryforwards and tax credits in the period they arise. Additionally, the Inflation Reduction Act of 2022 imposes an excise tax on the fair market value of net stock repurchases made after December 31, 2022. We do not believe the Corporate AMT will have a material impact on our consolidated financial position, results of operations, cash flows or related disclosures.

We account for income tax contingencies in accordance with FASB guidance that contains a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold, which all income tax positions must achieve before being recognized in the financial statements.

Property and Equipment: Property and equipment is recorded at cost, net of accumulated depreciation. Depreciation is computed principally by the straight-line method over estimated useful lives ranging from fifteen to thirty years for buildings and improvements, three to five years for computer equipment and software, and the lesser of the remaining life of the building lease, if any, or seven years for furniture and other equipment. Leasehold improvements are depreciated over the term of the related lease. Certain costs related to the development or purchase of internal-use software are capitalized and amortized over estimated useful lives ranging from three to ten years.

Goodwill and Other Intangible Assets: FASB guidance requires business combinations to be accounted for using the acquisition method of accounting, and it also specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Goodwill represents the excess of the cost of acquisition over the fair value of net assets acquired. Other intangible assets represent the values assigned to customer relationships, provider and hospital networks, Blue Cross and Blue Shield and other trademarks, licenses and other agreements, such as non-compete agreements. Goodwill and other intangible assets are allocated to reportable segments based on the relative fair value of the components of the businesses acquired.

Goodwill and other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually. Goodwill and other intangible assets are allocated to reporting units for purposes of the annual goodwill impairment test. Other intangible assets with indefinite lives, such as trademarks, are tested for impairment separately. We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets with indefinite lives. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur.

FASB guidance allows for qualitative assessments of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for purposes of a goodwill impairment analysis and whether it is more likely than not that an indefinite-lived intangible asset is impaired for purposes of an indefinite-lived intangible asset impairment analysis. Estimated fair values developed based on our assumptions and judgments might be different if other reasonable assumptions and estimates were to be used. Qualitative analysis involves assessing situations and developments that could affect key drivers used to evaluate whether the fair value of our goodwill and indefinite-lived intangible assets are impaired. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors, and entity specific events.

Quantitative analysis must be performed if qualitative analyses are not conclusive. Entities also have the option to bypass the assessment of qualitative factors and proceed directly to performing quantitative analyses. Fair value for purposes of a quantitative goodwill impairment test is calculated using a blend of the projected income and market valuation approaches. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. Our assumed discount rate is based on our industry's weighted-average cost of capital and reflects volatility associated with the cost of equity capital. Market valuations include market comparisons to publicly traded companies in our industry and are based on observed multiples of certain measures including revenue; earnings before interest, taxes, depreciation and amortization ("EBITDA"); and book value of invested capital.

A goodwill impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. This determination consists of a one-step test comparing the fair value of a reporting unit, including goodwill, to its carrying amount. If the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized. This goodwill impairment loss is equal to the excess of the reporting unit's carrying amount over its fair value.

Fair value for purposes of a quantitative impairment test for indefinite-lived intangible assets is estimated using a projected income approach. We recognize an impairment loss when the estimated fair value of indefinite-lived intangible assets is less than the carrying value. If significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Derivative Financial Instruments: We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, collars, swaptions, embedded derivatives and warrants. Derivatives embedded within non-derivative instruments, such as options embedded in convertible fixed maturity securities, are bifurcated from the host instrument when the embedded derivative is not clearly and closely related to the host instrument. Our use of derivatives is limited by statutes and regulations promulgated by the various regulatory bodies to which we are subject, and by our own derivative policy. Our derivative use is generally limited to hedging purposes, on an economic basis, and we generally do not use derivative instruments for speculative purposes.

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through active portfolio management, including rebalancing our existing portfolios of assets and liabilities, as well as changing the characteristics of investments to be purchased or sold in the future. In addition, derivative financial instruments are used to modify the interest rate exposure of certain liabilities or forecasted transactions. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge, on an economic basis, interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

All investments in derivatives are recorded as assets or liabilities at fair value. If certain correlation, hedge effectiveness and risk reduction criteria are met, a derivative may be specifically designated as a hedge of exposure to changes in fair value or cash flow. The accounting for changes in the fair value of a derivative depends on the intended use of the derivative and the nature of any hedge designation thereon. Amounts excluded from the assessment of hedge effectiveness, if any, are reported in results of operations immediately. If the derivative is not designated as a hedge, the gain or loss resulting from the change in the fair value of the derivative is recognized in results of operations in the period of change. Cash flows associated with the settlement of non-designated derivatives are shown on a net basis in investing activity in our consolidated statements of cash flow.

From time to time, we may also purchase derivatives to hedge, on an economic basis, our exposure to foreign currency exchange fluctuations associated with the operations of certain of our subsidiaries. We generally use futures or forward contracts for these transactions. We generally do not designate these contracts as hedges and, accordingly, the changes in fair value of these derivatives are recognized in results of operations immediately.

Credit exposure associated with non-performance by the counterparties to derivative instruments is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the consolidated balance sheets. We attempt to mitigate the risk of non-performance by selecting counterparties with high credit ratings and monitoring their creditworthiness and by diversifying derivatives among multiple counterparties. At December 31, 2022, we believe there were no material concentrations of credit risk with any individual counterparty.

We generally enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions with the same counterparty. Certain of our derivative agreements also contain credit support provisions that require us or the counterparty to post collateral if there are declines in the derivative fair value or our credit rating. The derivative assets and derivative liabilities are reported at their fair values net of collateral and netting by the counterparty.

Retirement Benefits: We recognize the funded status of pension and other postretirement benefit plans on the consolidated balance sheets based on fiscal-year-end measurements of plan assets and benefit obligations. Prepaid pension benefits represent prepaid costs related to defined benefit pension plans and are reported with other noncurrent assets. Postretirement benefits represent outstanding obligations for retiree medical, life, vision and dental benefits. Liabilities for pension and other postretirement benefits are reported with noncurrent assets, current liabilities and noncurrent liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

We determine the expected return on plan assets using the calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of net periodic benefit cost.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. We use the annual spot rate approach for setting our discount rate. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan's cash flows to determine the plan's obligations.

The assumed healthcare cost trend rates used to measure the expected cost of other postretirement benefits are based on an initial assumed healthcare cost trend rate declining to an ultimate healthcare cost trend rate over a select number of years.

Medical Claims Payable: Liabilities for medical claims payable include estimated provisions for incurred but not paid claims on an undiscounted basis, as well as estimated provisions for expenses related to the processing of claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems; and (2) claims reported to us and processed through our systems but not yet paid.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Our reserving practice for claim liabilities is to consistently recognize the appropriate amount of reserve within a level of confidence required by Actuarial Standards of Practice. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim payments. This information is analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels ("trend factors").

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are materially different than actual results, our income statement and financial position could be impacted in future periods.

Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. Determination of premium deficiencies for longer duration life and disability contracts includes consideration of investment income. For purposes of premium deficiencies, contracts are deemed to be either short or long duration and are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. Once established, premium deficiencies are released commensurate with actual claims experience over the remaining life of the contract. No premium deficiencies were established at December 31, 2022 or 2021.

Benefit expense includes incurred medical claims as well as quality improvement expenses for our risk-based members. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members.

Other Policyholder Liabilities: Other policyholder liabilities include rate stabilization reserves associated with retrospectively rated insurance contracts and certain case-specific reserves. Other policyholder liabilities also include liabilities for premium refunds based upon the minimum medical loss ratio ("MLR"), the relative health risk of members, and other contractual or regulatory requirements. Rate stabilization reserves represent accumulated premiums that exceed what customers owe us based on actual claim experience. The timing of payment of these retrospectively rated refunds is based on the contractual terms with our customers and can vary from period to period based on the specific contractual requirements.

We are required to meet certain minimum MLR thresholds prescribed by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively the "ACA"). If we do not meet or exceed the minimum MLR thresholds specified by the ACA, we are required to pay rebates to certain customers. Minimum MLR rebates are calculated by subsidiary, state and applicable line of business in accordance with regulations issued by the Department of Health and Human Services ("HHS"). Such calculations are made using estimated calendar year medical loss expense and premiums, as defined by HHS.

We follow HHS guidelines for determining the types of expenses that may be included in our minimum MLR rebate calculations, which differ from benefit expense and premiums as reported in our consolidated financial statements prepared in conformity with GAAP. Certain amounts reported as expense in our consolidated GAAP financial statements may be reported as a reduction of premiums in accordance with HHS regulations. In addition, profit amounts included in our payments to third-party administrative service providers are recorded as benefit expense in our consolidated GAAP financial statements, while HHS does not allow for the inclusion of these expenses within the medical loss expense for purposes of calculating minimum MLR.

Reserves for Future Policy Benefits: Reserves for future policy benefits include liabilities for life and long-term disability insurance policy benefits based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon our experience. Future policy benefits also include liabilities for insurance policies for which some of the premiums received in earlier years are intended to pay anticipated benefits to be incurred in future years. Future policy benefits are continually monitored and reviewed, and when reserves are adjusted, differences are reflected in benefit expense.

We believe that our liabilities for future policy benefits, along with future premiums received, are adequate to satisfy our ultimate benefit liability; however, these estimates are inherently subject to a number of variable circumstances. Consequently, the actual results could differ materially from the amounts recorded in our consolidated financial statements.

Revenue Recognition: Premiums for risk-based contracts are recognized as revenue over the period insurance coverage is provided, and, if applicable, net of amounts recognized for MLR rebates, risk adjustment, reinsurance and risk corridor under contractual premium stabilization arrangements, the ACA or other regulatory requirements. Premiums may also include performance incentives and penalties, which are recognized based on contractual terms. We estimate amounts receivable and payable under these contractual terms, and to the extent that such estimated amounts vary from the final amounts paid, the adjustments are included in earnings in the period of final settlement. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Premiums related to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheets as unearned income. Premiums include revenue adjustments for retrospectively rated contracts where revenue is based on the estimated loss experience of the contract. Premium rates for certain lines of business are subject to approval by the Department of Insurance of each respective state. Additionally, delays in annual premium rate changes from contracted government agencies require that we

defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized depending on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Service fees include revenue from certain group contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion, of their claims experience. We charge these fee-based groups an administrative fee, which is based on the number of members in a group and the group's claim experience. In addition, service fees include amounts received for the administration of Medicare, certain other government programs, and administrative services arrangements of our Carelon (Diversified Business Group) subsidiaries, now known as Carelon. Generally, these fee-based arrangements include services which constitute a single suite of services provided and for which consideration is based upon an agreed-upon rate, regardless of the amount of services provided in a given period. As with premiums, these fee-based arrangements may include terms with retroactive rate or membership adjustments, performance incentives and penalties, each of which is a form of variable consideration within the transaction price. As such, these fee-based arrangements contain a single performance obligation that constitutes a series, and revenue is recognized over time as the services are performed. All benefit payments under these programs are excluded from benefit expense.

The determination of whether services are distinct performance obligations that should be accounted for separately or combined as one unit of accounting may require significant judgment. The estimation of variable consideration to be recognized requires significant judgment in the determination of the level of achievement of performance incentives, service level achievements subject to performance penalties, and the completion level of tasks subject to implementation fees.

Product revenue includes revenue for services performed by CarelonRx for unaffiliated pharmacy customers. Unaffiliated pharmacy customers include our fee-based groups that have contracted with CarelonRx for pharmacy services and third-party health plans. Product revenues and costs of goods sold for our affiliated health plans are eliminated in consolidation. Product revenue for pharmacy services is recognized using the gross method at the negotiated contract price when CarelonRx has concluded that it is the principal and it controls the services before prescription drugs are transferred to the customer. CarelonRx determined it is the principal due to its contractual rights to design and develop a listing of prescription drugs offered to the customer (formulary management); its control over establishing the pharmacy network available to the customer to have its prescription fulfilled (network management); and its discretion over establishing the pricing for prescription drugs. Overall, control over these activities indicate CarelonRx is primarily responsible for fulfilling the promise to provide pharmacy services. Product revenue includes ingredient costs (net of any rebates or discounts), including any co-payments made by or on behalf of the customer, and administrative fees. CarelonRx recognizes revenue when control of the prescription drugs is transferred to customers, in an amount it expects to be entitled to in exchange for the products or services provided.

For our non-risk-based contracts, we had no material contract assets, contract liabilities or deferred contract costs recorded on our consolidated balance sheet at December 31, 2022. Revenue recognized in 2022 and 2021 from performance obligations related to prior years, such as due to changes in transaction price, was not material. For contracts that have an original expected duration of greater than one year, revenue expected to be recognized in future periods related to unfulfilled contractual performance obligations and contracts with variable consideration related to undelivered performance obligations is not material.

Cost of Products Sold: CarelonRx's cost of products sold includes the cost of prescription drugs dispensed to unaffiliated pharmacy customers (net of rebates or discounts). Cost of products sold includes per-claim administrative fees for prescription fulfillment by its vendor and certain CarelonRx direct costs related to sales and administration of customer contracts.

Share-Based Compensation: Our current compensation philosophy provides for share-based compensation, including stock options, restricted stock awards and an employee stock purchase plan. Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the date of the grant. Restricted stock awards are issued at the fair value of the stock on the grant date. The employee stock purchase plan allows for a purchase price per share which is 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter. The employee stock purchase plan discount is recognized as compensation expense based on GAAP guidance. All other share-

based payments to employees are recognized as compensation expense in our consolidated statements of income based on their fair values. Additionally, excess tax benefits, which result from actual tax benefits realized when awards vest or options are exercised exceeding deferred tax benefits previously recognized based on grant date fair value, are recognized as tax benefits in the consolidated statements of income.

***Advertising and Marketing Costs*:** We use print, broadcast and other advertising to promote our products and to develop our corporate image. We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Employer Group risk-based customers with a smaller employee base. Products for Employer Group risk-based 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 and Group markets, we offer products through state or federally facilitated marketplaces, or Public Exchanges, and off-exchange products. The cost of advertising and marketing for product promotion is expensed as incurred, while advertising and marketing costs associated with our corporate image are expensed when first aired. Total advertising and marketing expense was $511, $588 and $558 for the years ended December 31, 2022, 2021 and 2020, respectively.

***Health Insurance Provider Fee*:** The ACA imposed an annual Health Insurance Provider Fee ("HIP Fee") on health insurers that wrote certain types of health insurance on U.S. risks, which was permanently repealed effective January 1, 2021. The HIP Fee was non-deductible for federal income tax purposes. Our affected products were priced to cover the increased operating and income tax expenses associated with the HIP Fee when it was in effect. The HIP Fee was $15,523 for 2020 and was permanently eliminated beginning in 2021. For the year ended December 31, 2020, we recognized $1,570 as operating expense related to the HIP Fee.

Leases: We lease office space and certain computer and related equipment under noncancelable operating leases. We determine whether an arrangement is or contains a lease at its inception. We recognize lease liabilities based on the present value of the minimum lease payments not yet paid by using the lease term, any amounts probable of being owed under any residual value guarantees and the discount rate determined at lease commencement. As our leases do not generally provide an implicit rate, we use our incremental secured borrowing rate commensurate with the underlying lease terms to determine the present value of our lease payments. Our lease liabilities may include amounts for options to extend or terminate a lease when it is reasonably certain that we will exercise that option. We recognize operating right-of-use ("ROU") assets at an amount equal to the lease liability adjusted for prepaid or accrued rent, the remaining balance of any lease incentives and unamortized initial direct costs.

The operating lease liabilities are reported in other current liabilities and other noncurrent liabilities and the related ROU assets are reported in other noncurrent assets on our consolidated balance sheets. Lease expense for our operating leases is calculated on a straight-line basis over the lease term and is reported in operating expense on our consolidated statements of income. For our office space leases, we account for the lease and non-lease components (such as common area maintenance) as a single lease component. We also do not recognize a lease liability or ROU asset for our office space leases whose lease terms, at commencement, are twelve months or less and that do not include a purchase option or option to extend that we are reasonably certain to exercise.

We assess our ROU assets for impairment when there are indicators of impairment and compare the carrying amount of the ROU asset to its estimated undiscounted future cash flows. If the estimated undiscounted future cash flows are less than the carrying amount of the ROU asset, an impairment calculation is performed. An impairment loss is recorded for the difference of the ROU asset's carrying value that exceeds its estimated discounted cash flows. During the years ended December 31, 2022, 2021 and 2020, we recorded $34, $136 and $258, respectively, for impairment and abandonment of ROU assets. See Note 18, "Leases" for additional information about the ROU asset impairment and abandonment charges.

Earnings per Share: Earnings per share amounts, on a basic and diluted basis, have been calculated based upon the weighted-average common shares outstanding for the period.

Basic earnings per share excludes dilution and is computed by dividing income available to common shareholders by the weighted-average number of common shares outstanding for the period. Diluted earnings per share may include the dilutive effect of stock options, restricted stock and convertible debentures, using the treasury stock method. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase

common stock at the average market price for the period. The difference between the number of shares assumed issued and the number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Guidance: In January 2021, the FASB issued Accounting Standards Update No. 2021-01, *Reference Rate Reform (Topic 848)* ("ASU 2021-01"). The amendments in ASU 2021-01 provide optional expedients and exceptions for applying GAAP to contract modifications and hedging relationships, subject to meeting certain criteria, that reference the London Interbank Offered Rate ("LIBOR") or another reference rate expected to be discontinued because of the reference rate reform. The provisions must be applied at a Topic, Subtopic, or Industry Subtopic level for all transactions other than derivatives, which may be applied at a hedging relationship level. We adopted ASU 2021-01 on January 7, 2021, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In October 2020, the FASB issued Accounting Standards Update No. 2020-08, *Codification Improvements to Subtopic 310-20, Receivables—Nonrefundable Fees and Other Costs* ("ASU 2020-08"). The amendments in ASU 2020-08 clarify when an entity should assess whether a callable debt security is within the scope of accounting guidance, which impacts the amortization period for nonrefundable fees and other costs. ASU 2020-08 became effective for interim and annual reporting periods beginning after December 15, 2020. The amendments were applied on a prospective basis as of the beginning of the period of adoption for existing or newly purchased callable debt securities. We adopted ASU 2020-08 on January 1, 2021, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In August 2020, the FASB issued Accounting Standards Update No. 2020-06, *Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity's Own Equity (Subtopic 815-40): Accounting for Convertible Instruments and Contracts in an Entity's Own Equity* ("ASU 2020-06"). The amendments eliminate two of the three accounting models that require separate accounting for convertible features of debt securities, simplify the contract settlement assessment for equity classification, require the use of the if-converted method for all convertible instruments in the diluted earnings per share calculation and expand disclosure requirements. The amendments became effective for our annual and interim reporting periods beginning after December 15, 2021. We adopted ASU 2020-06 on January 1, 2022 using the modified retrospective transition method, which resulted in an increase to our reported debt outstanding of $31, a decrease to our deferred tax liabilities of $8, and a corresponding cumulative-effect reduction to our opening retained earnings of $23, eliminating the bifurcation of the embedded conversion option; these amounts were not material to our overall consolidated financial position. The adoption of ASU 2020-06 did not have an impact on our results of operations or our consolidated cash flows. Use of the if-converted method did not have an impact on our overall earnings per share calculation.

In December 2019, the FASB issued Accounting Standards Update No. 2019-12, *Income Taxes (Topic 740): Simplifying the Accounting for Income Taxes* ("ASU 2019-12"). The amendments in ASU 2019-12 remove certain exceptions to the general principles in Accounting Standards Codification Topic 740. The amendments also clarify and amend existing guidance to improve consistent application. The amendments became effective for our annual reporting periods beginning after December 15, 2020. The transition method (retrospective, modified retrospective, or prospective basis) related to the amendments depends on the applicable guidance, and all amendments for which there is no transition guidance specified are to be applied on a prospective basis. We adopted ASU 2019-12 on January 1, 2021, and the adoption did not have an impact on our consolidated financial position, results of operations or cash flows.

In November 2020, the FASB issued Accounting Standards Update No. 2020-11, *Financial Services—Insurance (Topic 944): Effective Date and Early Application* ("ASU 2020-11"). The amendments in ASU 2020-11 make changes to the effective date and early application of Accounting Standards Update No. 2018-12, *Financial Services—Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts* ("ASU 2018-12"), which was issued in November 2018. The amendments in ASU 2020-11 extended the original effective date by one year, with the amendments required for our interim and annual reporting periods beginning after December 15, 2022. This standard requires the Company to review cash flow assumptions for its long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. This standard also requires the Company to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount the Company's reserves for future policy benefits will be based on an estimate of the yield for an upper-medium grade fixed-income instrument with a duration profile matching that of the Company's liabilities. In addition, this standard changes the amortization method for deferred acquisition costs. The Company adopted the new standard on January 1, 2023, using the modified retrospective transition method for changes to the liability for future policy benefits and deferred

acquisition costs as of the earliest period presented, January 1, 2021. As a result of applying the long-duration standard using the modified retrospective method, adjustments of $(131), $54 and $0, respectively, were made to shareholders' net income for the years ended December 31, 2022, 2021 and 2020, which include adjustments to benefit expense of $155, $(74) and $0, respectively. In addition, the following balance sheet adjustments were made at years ended December 31, 2022 and 2021: $(17) and $(4), respectively, to total assets; $47 and $(39), respectively, to total liabilities; $13 and $(19), respectively, to accumulated other comprehensive loss; and $(64) and $35, respectively to shareholders' equity and total equity. The adoption did not have a material impact on our consolidated financial position, results of operations, cash flows, or related disclosures.

There were no other new accounting pronouncements that were issued or became effective during the year ended December 31, 2022 that had, or are expected to have, a material impact on our financial position, results of operations, cash flows or financial statement disclosures.

3. Business Acquisitions

Completed Acquisitions

During the year ended December 31, 2022, we completed business combinations for total cash consideration of approximately $752. These acquisitions included Integra MLTC, Inc. ("Integra"), acquired May 2022, which is a managed long-term care plan that serves New York state Medicaid members, enabling adults with long-term care needs and disabilities to live safely and independently in their own homes. The purchase prices for all business combinations were allocated to the tangible and intangible net assets acquired based on management's initial estimates of their fair values, of which $89 was allocated to finite-lived intangible assets, $250 to indefinite-lived intangible assets, and $145 to goodwill. The intangible assets and goodwill acquired were assigned to our Health Benefits reportable segment. The majority of goodwill is deductible for income tax purposes. As of December 31, 2022, the initial accounting for the acquisitions completed in 2022 had not been finalized. Any subsequent adjustments made to the assets acquired or liabilities assumed during the measurement period will be recorded as an adjustment to goodwill. The proforma effects of these acquisitions for prior periods were not material to our consolidated results of operations.

During the year ended December 31, 2021, we completed business combinations for total cash consideration of approximately $4,021. These acquisitions included myNEXUS, Inc. ("myNEXUS"), acquired April 2021, a comprehensive home-based nursing management company for payors, and MMM Holdings, LLC ("MMM"), acquired June 2021, including its Medicare Advantage plan, Medicaid plan, and other affiliated companies. The purchase prices for all business combinations were allocated to the tangible and intangible net assets acquired based on management's final estimates of their fair values, of which $1,577 was allocated to finite-lived intangible assets, $20 to indefinite-lived intangible assets, and $2,531 to goodwill, including measurement period adjustments of $10 during the year ended December 31, 2022. Of these amounts, $795 was allocated to our Carelon Services reportable segment and $3,333 to our Health Benefits reportable segment. The majority of goodwill is not deductible for income tax purposes.

Acquired tangible assets (liabilities) at the acquisition date were:

	2022	2021
Cash, cash equivalents and short-term investments	$ 170	$ 808
Accounts receivable and other current assets	240	295
Property, equipment and other long-term assets	109	102
Medical claims and other policyholder liabilities payable	(185)	(571)
Accounts payable and other current liabilities	(20)	(179)
Other long-term liabilities	(15)	(6)
Deferred tax liabilities	(32)	(556)
Total net tangible assets	$ 267	$ (107)

The preliminary purchase price allocations for the various business combinations are subject to adjustment as valuation analyses, primarily related to intangible assets and contingent and tax liabilities, are finalized.

Acquisition date fair values and weighted-average useful lives assigned to intangible assets include:

	2022		2021	
	Fair Value	Weighted Average Useful Life	Fair Value	Weighted Average Useful Life
Customer-related	$ 85	10 years	$ 1,313	13 years
Provider and hospital relationships	2	15 years	240	14 years
Other	2	0.5 years	24	13 years
State Medicaid licenses	250	Indefinite	20	Indefinite
Total intangible assets	$ 339		$ 1,597	

The results of operations and financial condition of acquired entities have been included in our consolidated results and the results of the corresponding operating segment as of the date of acquisition. Through December 31, 2022, the impact of the acquired entities on revenue and net earnings was not material. Unaudited pro forma revenues for the years ended December 31, 2022 and 2021 as if the acquisitions had occurred on January 1, 2021 were immaterial for both periods. The pro forma effects of the acquisitions on net earnings were immaterial for both years.

Pending Acquisitions

Louisiana Health Service & Indemnity Company (d/b/a Blue Cross and Blue Shield of Louisiana)

On January 23, 2023, we announced our entrance into an agreement to acquire Louisiana Health Service & Indemnity Company, d/b/a Blue Cross and Blue Shield of Louisiana, an independent licensee of the BCBSA that provides healthcare plans to the Individual, Employer Group, Medicaid and Medicare markets, primarily in the State of Louisiana. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. The acquisition is expected to close by the end of the fourth quarter of 2023 and is subject to standard closing conditions and customary approvals.

BioPlus Parent, LLC

On November 9, 2022, we announced our entrance into an agreement with CarepathRx Aggregator, LLC to acquire its specialty pharmacy division, which includes BioPlus Parent, LLC (“BioPlus”) and subsidiaries. BioPlus is one of the largest independent specialty pharmacy organizations in the United States and seeks to connect payors and providers of specialty pharmaceuticals to meet the medication therapy needs of patients with complex medical conditions. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. The acquisition was completed on February 15, 2023, and initial purchase accounting for the acquisition has not been finalized.

4. Business Optimization Initiatives

We believe that our properties are adequate and suitable for our business as presently conducted; however, we are continuing to evaluate our real estate strategy as it relates to the changing needs of a more hybrid remote workforce. As a result, during 2022, we identified additional reductions of office space and recorded a net charge of $39 in operating expense. This charge includes $34 for impairment and abandonment of operating-lease related ROU assets and $7 for impairment and abandonment of property and equipment. In addition, we released $2 of employee termination costs, as reflected in the table below. The net charges (benefits) recognized in the Health Benefits, CarelonRx, Carelon Services and Corporate & Other segments in 2022, were $36, $0, $5 and $(2), respectively. See Note 20, “Segment Information” for a discussion of our segments.

During 2021, we identified reductions of office space and recorded a charge of $202 in operating expense. This charge included $136 for impairment and abandonment of operating-lease related ROU assets and $66 for impairment and abandonment of property and equipment. The charges recognized in the Health Benefits, CarelonRx, Carelon Services and Corporate & Other segments in 2021, were $168, $1, $33 and $0, respectively.

During 2020, our management introduced enterprise-wide initiatives to optimize our business and, as a result, we recorded a charge of $653 in operating expense. This charge included $258 for impairment and abandonment of operating-lease related ROU assets, $198 for impairment and abandonment of property and equipment and $197 for future payments for employee termination costs in connection with the repositioning and reskilling of our workforce. The charges recognized in the Health Benefits, CarelonRx, Carelon Services and Corporate & Other segments in 2020, were $516, $4, $122 and $11, respectively.

A summary of the activity for the year ended December 31, 2022 and ending balance at December 31, 2022, related to the liability for employee termination costs previously incurred in 2020, is as follows:

	Health Benefits	CarelonRx	Carelon Services	Corporate & Other	Total
2020 Business Optimization Initiatives					
Liabilities for employee termination costs at January 1, 2022	$ 118	$ 1	$ —	$ 3	$ 122
Payments	(38)	—	—	(1)	(39)
Releases	—	—	—	(2)	(2)
Total liabilities for employee termination costs ending balance at December 31, 2022	$ 80	$ 1	$ —	$ —	$ 81

5. Investments

Certain prior year residential and commercial mortgage-backed securities have been reclassified throughout this Note 5 and Note 7, "Fair Value" to conform to the current year presentation.

A summary of current and long-term fixed maturity securities, available-for-sale, at December 31, 2022 and 2021 is as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Allowance For Credit Losses	Estimated Fair Value
December 31, 2022					
Fixed maturity securities:					
United States Government securities	$ 1,502	$ 2	$ (103)	$ —	$ 1,401
Government sponsored securities	82	1	(5)	—	78
Foreign government securities	321	1	(46)	(2)	274
States, municipalities and political subdivisions, tax-exempt	4,389	19	(265)	—	4,143
Corporate securities	13,721	31	(1,218)	(5)	12,529
Residential mortgage-backed securities	2,978	9	(324)	—	2,663
Commercial mortgage-backed securities	2,055	1	(176)	(2)	1,878
Other asset-backed securities	3,967	12	(241)	—	3,738
Total fixed maturity securities	$ 29,015	$ 76	$ (2,378)	$ (9)	$ 26,704
December 31, 2021					
Fixed maturity securities:					
United States Government securities	$ 1,443	$ 7	$ (18)	$ —	$ 1,432
Government sponsored securities	65	4	(1)	—	68
Foreign government securities	353	7	(13)	—	347
States, municipalities and political subdivisions, tax-exempt	5,321	310	(10)	—	5,621
Corporate securities	12,044	401	(78)	(4)	12,363
Residential mortgage-backed securities	2,492	48	(22)	—	2,518
Commercial mortgage-backed securities	1,632	29	(16)	(2)	1,643
Other asset-backed securities	2,907	24	(24)	—	2,907
Total fixed maturity securities	$ 26,257	$ 830	$ (182)	$ (6)	$ 26,899

Other asset-backed securities primarily consist of collateralized loan obligations and other debt securities.

For fixed maturity securities in an unrealized loss position at December 31, 2022 and 2021, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position.

	Less than 12 Months			12 Months or Greater		
	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
(Securities are whole amounts)						
December 31, 2022						
Fixed maturity securities:						
United States Government securities	61	$ 701	$ (40)	38	$ 442	$ (63)
Government sponsored securities	39	73	(4)	6	5	(1)
Foreign government securities	150	100	(10)	198	142	(36)
States, municipalities and political subdivisions, tax-exempt	1,398	2,615	(147)	396	652	(118)
Corporate securities	3,551	7,826	(549)	2,204	3,521	(669)
Residential mortgage-backed securities	1,341	1,435	(121)	496	982	(203)
Commercial mortgage-backed securities	457	1,082	(76)	324	719	(100)
Other asset-backed securities	784	2,203	(124)	398	1,074	(117)
Total fixed maturity securities	7,781	$ 16,035	$ (1,071)	4,060	$ 7,537	$ (1,307)
December 31, 2021						
Fixed maturity securities:						
United States Government securities	51	$ 990	$ (11)	27	$ 176	$ (7)
Government sponsored securities	—	—	—	1	1	(1)
Foreign government securities	188	143	(8)	68	41	(5)
States, municipalities and political subdivisions, tax-exempt	281	634	(9)	8	16	(1)
Corporate securities	1,846	3,310	(57)	403	485	(21)
Residential mortgage-backed securities	422	1,295	(19)	63	44	(3)
Commercial mortgage-backed securities	272	676	(8)	66	137	(8)
Other asset-backed securities	511	1,707	(19)	50	85	(5)
Total fixed maturity securities	3,571	$ 8,755	$ (131)	686	$ 985	$ (51)

Unrealized losses on our securities shown in the table above have not been recognized into income because, as of December 31, 2022, we do not intend to sell these investments and it is likely that we will not be required to sell these investments prior to their anticipated recovery. The declines in fair values are largely due to increasing interest rates driven by the higher rate of inflation and other market conditions.

Allowances for credit losses have been recorded in the amounts of $9 and $6 at December 31, 2022 and 2021, respectively, for declines in fair value due to unfavorable changes in the credit quality characteristics that impact our assessment of collectability of principal and interest.

The amortized cost and fair value of fixed maturity securities at December 31, 2022, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 726	$ 720
Due after one year through five years	7,489	7,095
Due after five years through ten years	9,512	8,703
Due after ten years	6,255	5,645
Mortgage-backed securities	5,033	4,541
Total fixed maturity securities	$ 29,015	$ 26,704

Equity Securities

A summary of current equity securities at December 31, 2022 and 2021 is as follows:

	December 31, 2022	December 31, 2021
Equity Securities:		
Exchange traded funds	$ 822	$ 1,750
Common equity securities	43	42
Private equity securities	88	89
Total	$ 953	$ 1,881

Investment Income

The major categories of net investment income for the years ended December 31, 2022, 2021 and 2020 are as follows:

	2022	2021	2020
Fixed maturity securities	$ 971	$ 755	$ 725
Equity securities	48	43	71
Cash equivalents	77	5	28
Other invested assets	432	616	91
Investment income	1,528	1,419	915
Investment expenses	(43)	(41)	(38)
Net investment income	$ 1,485	$ 1,378	$ 877

Investment (Losses) Gains

Net investment (losses) gains for the years ended December 31, 2022, 2021 and 2020 are as follows:

	2022	2021	2020
Net gains (losses):			
Fixed maturity securities:			
Gross realized gains from sales	$ 52	$ 170	$ 175
Gross realized losses from sales	(469)	(44)	(105)
Impairment (losses) recoveries recognized in income	(31)	1	(7)
Net realized gains on fixed maturity securities	(448)	127	63
Equity securities:			
Unrealized (losses) gains recognized on equity securities still held	(78)	2	133
Net realized (losses) gains recognized on equity securities sold	(102)	(73)	61
Net (losses) gains on equity securities	(180)	(71)	194
Other investments:			
Gross gains	96	293	18
Gross losses	(64)	(22)	—
Impairment losses recognized in income	(34)	(16)	(91)
Net (losses) gains on other investments	(2)	255	(73)
Net (losses) gains on investments	$ (630)	$ 311	$ 184

A primary objective in the management of our fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses. In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectations that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

Total proceeds from sales, maturities, calls or redemptions of fixed maturity securities was $22,048, $10,565 and $11,122 for the years ended December 31, 2022, 2021 and 2020, respectively.

A significant judgment in the valuation of investments is the determination of when a credit loss has occurred. We follow a consistent and systematic process for recognizing impairments on securities that sustain credit declines in value. We have established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors including, but not limited to: (i) the extent to which the fair value is less than book value, (ii) the financial condition and near term prospects of the issuer, (iii) our intent and ability to retain impaired investments for a period of time sufficient to allow for any anticipated recovery in fair value, (iv) our intent to sell or the likelihood that we will need to sell a fixed maturity security before recovery of its amortized cost basis, (v) whether the debtor is current on interest and principal payments, (vi) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (vii) general market conditions and industry or sector specific factors. When a decision has been made to sell an impaired security or it is more likely than not that the impaired security will be required to be disposed of prior to recovery of its cost basis, the security is written down to fair value at the reporting date. For all other impaired securities, if the impairment is deemed to be credit related, an allowance is created.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is possible that changes in these risk factors in the near term could have a material adverse impact on our results of operations or shareholders' equity.

At December 31, 2022 and 2021, there were no individual investments that exceeded 10% of shareholders' equity.

At December 31, 2022 and 2021, there were eight and two, respectively, fixed maturity investments that did not produce income during the years then ended.

As of December 31, 2022 and 2021, we had committed approximately $1,504 and $1,558, respectively, to future capital calls from various third-party investments in exchange for an ownership interest in the related entities.

As of December 31, 2022 and 2021, we had committed approximately $185 and $329, respectively, to future investments in rated notes.

At December 31, 2022 and 2021, securities with carrying values of approximately $752 and $632, respectively, were deposited by our insurance subsidiaries under requirements of regulatory authorities.

Accrued Investment Income

Accrued investment income totaled $245 and $205 at December 31, 2022 and 2021, respectively. We recognize accrued investment income under the caption "Other receivables" on our consolidated balance sheets.

Securities Lending Programs

The fair value of the collateral received at the time of the securities lending transactions amounted to $2,457 and $2,155 at December 31, 2022 and 2021, respectively. The value of the collateral represented 102% of the market value of the securities on loan at each of December 31, 2022 and 2021.

We recognize the collateral as an asset under the caption "Other current assets" in our consolidated balance sheets, and we recognize a corresponding liability for the obligation to return the collateral to the borrower under the caption "Other current liabilities." The securities on loan are reported in the applicable investment category on our consolidated balance sheets.

At December 31, 2022 and 2021, the remaining contractual maturities of our securities lending transactions included overnight and continuous transactions of cash for $2,221 and $1,874, respectively, United States Government securities for $224 and $281, respectively, and residential mortgage-backed securities for $12 and $0, respectively.

6. Derivative Financial Instruments

We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, collars, swaptions, embedded derivatives and warrants. We also enter into master netting agreements which reduce credit risk by permitting net settlement of transactions. At December 31, 2022 and 2021, we had received collateral of $57 and $18, respectively, related to our derivative financial instruments.

A summary of the aggregate contractual or notional amounts and estimated fair values related to derivative financial instruments at December 31, 2022 and 2021 is as follows:

	Contractual/ Notional Amount	Balance Sheet Location	Estimated Fair Value	
			Asset	(Liability)
December 31, 2022				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 1,125	Other assets/other liabilities	$ 3	$ (60)
Non-hedging instruments				
Derivatives embedded in convertible fixed maturity securities	18	Fixed Maturity Securities	4	—
Interest rate swaps	5	Equity securities/other assets/ other liabilities	—	—
Options	—	Other assets/other liabilities	1	—
Collars	19	Equity securities	23	(9)
Futures	358	Equity securities	2	(2)
Subtotal non-hedging	400	Subtotal non-hedging	30	(11)
Total derivatives	$ 1,525	Total derivatives	33	(71)
		Amounts netted	(12)	12
		Net derivatives	$ 21	$ (59)
December 31, 2021				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 825	Other assets/other liabilities	$ 23	$ (5)
Non-hedging instruments				
Interest rate swaps	119	Equity securities/other assets/ other liabilities	—	(5)
Options	100	Other assets/other liabilities	—	—
Collars	19	Equity securities	21	(17)
Futures	344	Equity securities	3	(2)
Subtotal non-hedging	582	Subtotal non-hedging	24	(24)
Total derivatives	$ 1,407	Total derivatives	47	(29)
		Amounts netted	(21)	21
		Net derivatives	$ 26	$ (8)

Fair Value Hedges

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to the LIBOR or the Secured Overnight Financing Rate. A summary of our outstanding fair value hedges at December 31, 2022 and 2021 is as follows:

Type of Fair Value Hedges	Year Entered Into	Outstanding Notional Amount		Interest Rate Received	Expiration Date
		2022	2021		
Interest rate swap	2022	$ 150	$ —	5.500 %	April 15, 2032
Interest rate swap	2022	75	—	4.101	September 1, 2027
Interest rate swap	2022	75	—	2.250	November 15, 2029
Interest rate swap	2021	150	150	2.550	September 15, 2030
Interest rate swap	2021	100	100	2.250	November 15, 2029
Interest rate swap	2020	75	75	4.101	September 1, 2027
Interest rate swap	2018	50	50	4.101	September 1, 2027
Interest rate swap	2018	450	450	3.300	January 15, 2023
Total notional amount outstanding		$ 1,125	$ 825		

The following amounts were recorded on our consolidated balance sheets related to cumulative basis adjustments for fair value hedges at December 31, 2022 and 2021:

Balance Sheet Classification in Which Hedged Item is Included	Carrying Amount of Hedged Liability		Cumulative Amount of Fair Value Hedging Adjustment Included in the Carrying Amount of the Hedged Liability	
	2022	2021	2022	2021
Long-term debt	$ 22,349	$ 21,157	$ (57)	$ 18

Cash Flow Hedges

We have entered into a series of forward starting pay fixed interest rate swaps with the objective of eliminating the variability of cash flows in the interest payments on future financings that were anticipated at the time of entering into the swaps. During 2022 and 2021, swaps in the notional amount of $700 and $450, respectively, were terminated.

The unrecognized loss for all expired and terminated cash flow hedges included in accumulated other comprehensive loss, net of tax, was $229 and $239 at December 31, 2022 and 2021, respectively. As of December 31, 2022, the total amount of amortization over the next twelve months for all cash flow hedges is estimated to increase interest expense by approximately $13. No amounts were excluded from effectiveness testing.

Non-Hedging Derivatives

A summary of the effect of non-hedging derivatives on our consolidated statements of income for the years ended December 31, 2022, 2021 and 2020 is as follows:

Type of Non-hedging Derivatives	Income Statement Location of Gain (Loss) Recognized	Derivative (Loss) Gain Recognized
Year ended December 31, 2022		
Derivatives embedded in convertible securities	Net (losses) gains on financial instruments	$ (3)
Interest rate swaps	Net (losses) gains on financial instruments	(4)
Options (including swaptions)	Net (losses) gains on financial instruments	13
Collars	Net (losses) gains on financial instruments	10
Futures	Net (losses) gains on financial instruments	64
Total		$ 80
Year ended December 31, 2021		
Interest rate swaps	Net (losses) gains on financial instruments	$ (4)
Collars	Net (losses) gains on financial instruments	4
Futures	Net (losses) gains on financial instruments	7
Total		$ 7
Year ended December 31, 2020		
Interest rate swaps	Net (losses) gains on financial instruments	$ (1)
Options	Net (losses) gains on financial instruments	(5)
Futures	Net (losses) gains on financial instruments	4
Total		$ (2)

7. Fair Value

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in the consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less, and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. Level II securities primarily include corporate securities, securities from states, municipalities and political

subdivisions, mortgage-backed securities, United States Government securities, foreign government securities, and certain other asset-backed securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily collateralized loan obligation securities and corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available, and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, and/or revenue multiples that are not observable in the markets.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate market observable inputs for similar derivative transactions. Derivatives are designated as Level II securities. Derivatives presented within the fair value hierarchy table below are presented on a gross basis and not on a master netting basis by counterparty.

In addition, the following methods and assumptions were used to determine the fair value of each class of pension benefit plan assets and other benefit plan assets not defined above (see Note 11, "Retirement Benefits," for fair values of benefit plan assets):

Mutual funds: Fair values are based on quoted market prices, which represent the net asset value ("NAV") of the shares held.

Partnership investments: Fair values are estimated based on the plan's proportionate share of the undistributed partners' capital as reported in audited financial statements of the partnership. In accordance with FASB guidance, certain investments that are measured at fair value using the NAV per share as a practical expedient or the fair value measurement alternative have been classified in the fair value hierarchy. The fair value amounts presented are intended to permit reconciliation of the fair value hierarchy to the total investments of the master trust.

Commingled fund: Fair value is based on NAV per fund share, primarily derived from the quoted prices in active markets on the underlying equity securities.

Contract with insurance company: Fair value of the contract in the insurance company general investment account is determined by the insurance company based on the fair value of the underlying investments of the account.

Investment in DOL 103-12 trust: Fair value is based on the plan's proportionate share of the fair value of investments held by the trust, qualified as a Department of Labor Regulation 2520.103-12 entity ("DOL 103-12 trust") as reported in the audited financial statements of the trust, where the trustee applies fair value measurements to the underlying investments of the trust.

Life insurance contracts: Fair value is based on the cash surrender value of the policies as reported by the insurer.

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at December 31, 2022 and 2021 is as follows:

	Level I	Level II	Level III	Total
December 31, 2022				
Assets:				
Cash equivalents	$ 3,567	$ —	$ —	$ 3,567
Fixed maturity securities, available-for-sale:				
United States Government securities	—	1,401	—	1,401
Government sponsored securities	—	78	—	78
Foreign government securities	—	274	—	274
States, municipalities and political subdivisions, tax-exempt	—	4,143	—	4,143
Corporate securities	—	12,392	137	12,529
Residential mortgage-backed securities	—	2,663	—	2,663
Commercial mortgage-backed securities	—	1,878	—	1,878
Other asset-backed securities	—	3,382	356	3,738
Total fixed maturity securities, available-for-sale	—	26,211	493	26,704
Equity securities:				
Exchange traded funds	822	—	—	822
Common equity securities	2	41	—	43
Private equity securities	—	—	88	88
Total equity securities	824	41	88	953
Other invested assets - common equity securities	103	—	—	103
Securities lending collateral	—	2,457	—	2,457
Derivatives - other assets	—	3	—	3
Total assets	$ 4,494	$ 28,712	$ 581	$ 33,787
Liabilities:				
Derivatives - other liabilities	$ —	$ (60)	$ —	$ (60)
Total liabilities	$ —	$ (60)	$ —	$ (60)
December 31, 2021				
Assets:				
Cash equivalents	$ 2,415	$ —	$ —	$ 2,415
Fixed maturity securities, available-for-sale:				
United States Government securities	—	1,432	—	1,432
Government sponsored securities	—	68	—	68
Foreign government securities	—	347	—	347
States, municipalities and political subdivisions, tax-exempt	—	5,621	—	5,621
Corporate securities	—	12,027	336	12,363
Residential mortgage-backed securities	—	2,513	5	2,518
Commercial mortgage-backed securities	—	1,643	—	1,643
Other asset-backed securities	—	2,888	19	2,907
Total fixed maturity securities, available-for-sale	—	26,539	360	26,899
Equity securities:				
Exchange traded funds	1,750	—	—	1,750
Common equity securities	8	34	—	42
Private equity securities	—	—	89	89
Total equity securities	1,758	34	89	1,881
Other invested assets - common equity securities	138	—	—	138
Securities lending collateral	—	2,155	—	2,155
Derivatives - other assets	—	19	—	19
Total assets	$ 4,311	$ 28,747	$ 449	$ 33,507
Liabilities:				
Derivatives - other liabilities	$ —	$ (1)	$ —	$ (1)
Total liabilities	$ —	$ (1)	$ —	$ (1)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the years ended December 31, 2022, 2021 and 2020 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Other Asset-Backed Securities	Equity Securities	Total
Year ended December 31, 2022					
Beginning balance at January 1, 2022	$ 336	$ 5	$ 19	$ 89	$ 449
Total gains (losses):					
Recognized in net income	—	—	(1)	—	(1)
Recognized in accumulated other comprehensive income	(1)	—	(16)	—	(17)
Purchases	56	—	370	17	443
Sales	(210)	—	(14)	(18)	(242)
Settlements	(41)	—	—	—	(41)
Transfers into Level III	9	—	—	—	9
Transfers out of Level III	(12)	(5)	(2)	—	(19)
Ending balance at December 31, 2022	$ 137	$ —	$ 356	$ 88	$ 581
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2022	$ —	$ —	$ —	$ —	$ —
Year ended December 31, 2021					
Beginning balance at January 1, 2021	$ 325	$ 2	$ 5	$ 60	$ 392
Total gains (losses):					
Recognized in net income	2	—	—	17	19
Recognized in accumulated other comprehensive income	3	—	—	—	3
Purchases	179	4	17	16	216
Sales	(18)	—	—	(4)	(22)
Settlements	(157)	—	—	—	(157)
Transfers into Level III	3	—	—	—	3
Transfers out of Level III	(1)	(1)	(3)	—	(5)
Ending balance at December 31, 2021	$ 336	$ 5	$ 19	$ 89	$ 449
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2021	$ —	$ —	$ —	$ 18	$ 18
Year ended December 31, 2020					
Beginning balance at January 1, 2020	$ 303	$ 2	$ 7	$ 85	$ 397
Total gains (losses):					
Recognized in net income	(3)	—	—	(19)	(22)
Recognized in accumulated other comprehensive income	(5)	—	—	—	(5)
Purchases	85	—	—	16	101
Sales	(19)	—	—	(22)	(41)
Settlements	(44)	—	(2)	—	(46)
Transfers into Level III	10	—	—	—	10
Transfers out of Level III	(2)	—	—	—	(2)
Ending balance at December 31, 2020	$ 325	$ 2	$ 5	$ 60	$ 392
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2020	$ —	$ —	$ —	$ (19)	$ (19)

There were no individually material transfers into or out of Level III during the years ended December 31, 2022, 2021 or 2020.

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, “Business Acquisitions,” we completed our acquisition of Integra in 2022 and the acquisitions of myNEXUS and MMM

during 2021. The net assets acquired in our acquisitions of Integra, myNEXUS, and MMM and resulting goodwill and other intangible assets were recorded at fair value primarily using Level III inputs. The majority of assets acquired and liabilities assumed were recorded at their carrying values as of the respective date of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in our acquisitions of Integra, myNEXUS and MMM were internally estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation. Other than the assets acquired and liabilities assumed in our acquisitions of Integra, myNEXUS and MMM described above, there were no material assets or liabilities measured at fair value on a nonrecurring basis during the years ended December 31, 2022 or 2021.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes, unobservable inputs or other valuation techniques. These techniques are significantly affected by our assumptions, including discount rates and estimates of future cash flows. The use of assumptions for unobservable inputs for the determination of fair value involves a level of judgment and uncertainty. Changes in assumptions that reasonably could have been different at the reporting date may result in a higher or lower determination of fair value. Changes in fair value measurements, if significant, may affect performance of cash flows.

Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain quoted prices for each security from third-party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2022, 2021 or 2020.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as real estate, property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, premium receivables, self-funded receivables, other receivables, unearned income, accounts payable and accrued expenses, and certain other current liabilities approximate fair value because of the short-term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value on the consolidated balance sheets:

Other invested assets: Other invested assets primarily include our investments in limited partnerships, joint ventures and other non-controlled corporations and mortgage loans, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. Mortgage loans are carried at amortized cost, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—commercial paper: The carrying amount for commercial paper approximates fair value, as the underlying instruments have variable interest rates at market value.

Long-term debt—senior unsecured notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at December 31, 2022 and 2021 is as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
December 31, 2022					
Assets:					
Other invested assets	$ 5,582	$ —	$ —	$ 5,582	$ 5,582
Liabilities:					
Debt:					
Short-term borrowings	265	—	265	—	265
Notes	23,786	—	21,861	—	21,861
Convertible debentures	63	—	463	—	463
December 31, 2021					
Assets:					
Other invested assets	$ 5,087	$ —	$ —	$ 5,087	$ 5,087
Liabilities:					
Debt:					
Short-term borrowings	275	—	275	—	275
Commercial paper	300	—	300	—	300
Notes	22,384	—	25,150	—	25,150
Convertible debentures	72	—	687	—	687

8. Income Taxes

The components of deferred income taxes at December 31, 2022 and 2021 are as follows:

	2022	2021
Deferred income tax assets:		
Accrued expenses	$ 379	$ 511
Bad debt reserves	301	246
Insurance reserves	166	146
Lease liabilities	200	216
Retirement liabilities	173	170
Deferred compensation	34	35
Federal and state operating loss carryforwards	208	201
Investment basis	340	—
Other	267	207
Subtotal	2,068	1,732
Less: valuation allowance	(203)	(212)
Total deferred income tax assets	1,865	1,520
U.S. federal and state intangible assets	2,059	2,071
Foreign (including Puerto Rico) intangible assets	380	452
Capitalized software	601	777
Depreciation and amortization	62	45
Investment basis	—	295
Retirement assets	317	314
Lease right-of-use asset	123	126
Prepaid expenses	201	152
Total deferred income tax liabilities	3,743	4,232
Net deferred income tax liabilities	$ 1,878	$ 2,712

We recognized $137 and $103 of deferred tax asset under the caption “Other noncurrent assets” at December 31, 2022 and 2021, respectively. We recognized $2,015 and $2,815 of deferred tax liability under the caption “Deferred tax liabilities, net” at December 31, 2022 and 2021.

As of December 31, 2022, we have established U.S. deferred taxes for undistributed earnings from certain non-U.S. subsidiaries, which are included in the Investment basis component above, consistent with prior years.

Significant components of the provision for income taxes for the years ended December 31, 2022, 2021 and 2020 consist of the following:

	2022	2021	2020
Current tax expense:			
Federal	$ 1,469	$ 1,467	$ 1,724
Foreign (including Puerto Rico)	98	18	7
State and local	179	165	461
Total current tax expense	1,746	1,650	2,192
Deferred tax expense (benefit)	(34)	196	(526)
Total income tax expense	$ 1,712	$ 1,846	$ 1,666

State and local current tax expense is reported gross of federal benefit in the preceding table, and includes amounts related to audit settlements, uncertain tax positions, state tax credits and true up of prior years' tax. Such items are included on a net of federal tax basis in multiple lines in the following rate reconciliation table.

A reconciliation of income tax expense recorded in the consolidated statements of income and amounts computed at the statutory federal income tax rate for the years ended December 31, 2022, 2021 and 2020 is as follows:

	2022		2021		2020	
	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	$ 1,595	21.0 %	$ 1,679	21.0 %	$ 1,310	21.0 %
State and local income taxes net of federal tax expense/benefit	236	3.1	259	3.3	235	3.8
Tax exempt interest and dividends received deduction	(19)	(0.3)	(22)	(0.3)	(22)	(0.4)
HIP fee	—	—	—	—	330	5.3
Basis adjustments from recent acquisitions	—	—	—	—	(110)	(1.8)
Other, net	(100)	(1.3)	(70)	(0.9)	(77)	(1.2)
Total income tax expense	$ 1,712	22.5 %	$ 1,846	23.1 %	$ 1,666	26.7 %

During the year ended December 31, 2022, we recognized income tax expense of $1,712, or $7.05 per diluted share. The decrease in effective income tax rate is primarily due to the impact of geographic changes in the mix of 2022 earnings.

During the year ended December 31, 2021, we recognized income tax expense of $1,846, or $7.48 per diluted share. The HIP Fee payment was eliminated beginning in 2021.

During the year ended December 31, 2020, we recognized income tax expense of $1,666, or $6.55 per diluted share, which included income tax expense of $330, or $1.30 per diluted share, as a result of the non-tax deductibility of the HIP Fee payment.

The change in the carrying amount of gross unrecognized tax benefits from uncertain tax positions for the years ended December 31, 2022 and 2021 is as follows:

	2022	2021
Balance at January 1	$ 271	$ 249
Additions based on:		
Tax positions related to current year	22	10
Tax positions related to prior years	57	17
Reductions based on:		
Tax positions related to prior years	(1)	(5)
Balance at December 31	$ 349	$ 271

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. The interest is included in the amounts described in the following paragraph.

The amount of unrecognized tax benefits that would impact our effective tax rate in future periods, if recognized, was $328 and $250 at December 31, 2022 and 2021, respectively. Also included in the table above, at December 31, 2022, is $2 that would be recognized as an adjustment to additional paid-in capital, which would not affect our effective tax rate. In addition to the contingent liabilities included in the table above, we filed protective state income tax refund claims of approximately $92 and $310 for 2022 and 2017, respectively. There were no equivalent protective state income tax refund claims filed in 2021, 2020, 2019 or 2018.

For the years ended December 31, 2022, 2021 and 2020 we recognized net interest expense of $13, $9 and $7, respectively. We had accrued approximately $55 and $42 for the payment of interest at December 31, 2022 and 2021, respectively.

As of December 31, 2022, as further described below, certain tax years remain open to examination by the Internal Revenue Service ("IRS") and various state, local and foreign authorities. As a result of these examinations and discussions with taxing agencies, we have recorded amounts for uncertain tax positions. It is anticipated that the amount of unrecognized tax benefits will change in the next twelve months due to possible settlements of audits and changes in temporary items. However, the ultimate resolution of these items is dependent on the completion of negotiations with various taxing authorities. While it is difficult to determine when other tax settlements will actually occur, it is reasonably possible that one could occur in the next twelve months and our unrecognized tax benefits could be reduced within a range of approximately $33 to $143.

We are a member of the IRS Compliance Assurance Process ("CAP"). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations.

As of December 31, 2022, the IRS examination of our 2022 and 2021 tax years continues to be in process.

In certain states, we pay premium taxes in lieu of state income taxes. Premium taxes are reported in operating expense.

At December 31, 2022, we had federal net operating loss carryforwards of $160 that will expire beginning 2032 through 2042 and $109 that have an indefinite carryforward period. State net operating loss carryforwards expire beginning 2023 through 2042, with some having an indefinite carryforward period.

Income taxes receivable totaled $440 and $173 at December 31, 2022 and 2021, respectively. We recognize the income tax receivable as an asset under the caption "Other current assets" in our consolidated balance sheets.

During 2022, 2021 and 2020, federal income taxes paid totaled $1,594, $1,299 and $1,790, respectively.

9. Property and Equipment

A summary of property and equipment at December 31, 2022 and 2021 is as follows:

	2022	2021
Computer software, purchased and internally developed	$ 5,604	$ 6,115
Computer equipment, furniture and other equipment	828	1,314
Leasehold improvements	648	641
Building and improvements	38	172
Land and improvements	1	17
Property and equipment, gross	7,119	8,259
Accumulated depreciation and amortization	(2,803)	(4,340)
Property and equipment, net	$ 4,316	$ 3,919

Depreciation expense for 2022, 2021 and 2020 was $123, $136 and $176, respectively. Amortization expense on computer software and leasehold improvements for 2022, 2021 and 2020 was $661, $532 and $462, respectively, which includes amortization expense on computer software, both purchased and internally developed, for 2022, 2021 and 2020 of $599, $485 and $412, respectively. Capitalized costs related to the internal development of software of $5,354 and $5,626 at December 31, 2022 and 2021, respectively, are reported with computer software.

Impairment of property and equipment for the years ended December 31, 2022, 2021 and 2020 was $7, $73, and $198, respectively, which is included in operating expense and primarily related to our activities disclosed in Note 4, "Business Optimization Initiatives."

10. Goodwill and Other Intangible Assets

A summary of the change in the carrying amount of goodwill for our segments (see Note 20, "Segment Information") for 2022 and 2021 is as follows:

	Health Benefits	CarelonRx	Carelon Services	Total
Balance as of January 1, 2021	$ 19,924	$ 48	$ 1,719	$ 21,691
Acquisitions and adjustments	2,018	11	508	2,537
Balance as of December 31, 2021	21,942	59	2,227	24,228
Acquisitions and adjustments	146	—	9	155
Balance as of December 31, 2022	$ 22,088	$ 59	$ 2,236	$ 24,383
Accumulated impairment as of December 31, 2022	$ —	$ —	$ —	$ —

As required by FASB guidance, we completed annual impairment tests of existing goodwill and other intangible assets with indefinite lives during 2022, 2021 and 2020. We perform these annual impairment tests during the fourth quarter. FASB guidance also requires interim impairment testing to be performed when potential impairment indicators exist. These tests involve the use of estimates related to the fair value of goodwill and intangible assets with indefinite lives and require a significant degree of management judgment and the use of subjective assumptions. Qualitative testing procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. For quantitative testing, the fair values are estimated using the projected income and market valuation approaches, incorporating Level III internal estimates for inputs, including, but not limited to, revenue projections, income projections, cash flows and discount rates. We did not incur any impairment losses in 2022, 2021 or 2020, as the estimated fair values of our reporting units were substantially in excess of their carrying values.

The components of other intangible assets as of December 31, 2022 and 2021 are as follows:

	2022			2021		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Intangible assets with finite lives:						
Customer relationships	$ 5,791	$ (3,693)	$ 2,098	$ 5,598	$ (3,236)	$ 2,362
Provider and hospital relationships	326	(146)	180	324	(129)	195
Other	1,010	(440)	570	610	(141)	469
Total	7,127	(4,279)	2,848	6,532	(3,506)	3,026
Intangible assets with indefinite lives:						
Blue Cross and Blue Shield and other trademarks	5,991	—	5,991	6,299	—	6,299
State Medicaid licenses	1,476	—	1,476	1,290	—	1,290
Total	7,467	—	7,467	7,589	—	7,589
Other intangible assets	$ 14,594	$ (4,279)	$ 10,315	$ 14,121	$ (3,506)	$ 10,615

In 2022, due to our acquisition of Integra, we recorded intangible assets and due to our new branding strategy, reclassified $308 of trademarks with indefinite lives to Intangible assets with finite lives - Other. In addition, the amortization period of certain intangible assets was shortened to align with the anticipated dates the new branding will take place.

Intangible assets, along with the related accumulated amortization, are removed from the table above at the end of the fiscal year in which they become fully amortized.

As of December 31, 2022, the estimated amortization expense for each of the five succeeding years is as follows: 2023, $806; 2024, $370; 2025, $311; 2026, $258; and 2027, $221.

11. Retirement Benefits

We sponsor various non-contributory employee defined benefit plans through certain subsidiaries.

The Elevance Health Cash Balance Plan A (formerly the Anthem Cash Balance Plan A) and the Elevance Health Cash Balance Plan B (formerly the Anthem Cash Balance Plan B) are cash balance pension plans covering certain eligible employees of the affiliated companies that participate in these plans. Effective January 1, 2006, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits accrued prior to the curtailment. Certain participants subject to collective bargaining and certain other participants who met grandfathering rules continued to accrue benefits. Participants who did not receive credits and/or benefit accruals were included in the Elevance Health Cash Balance Plan A, while employees who were still receiving credits and/or benefits participated in the Elevance Health Cash Balance Plan B. Effective January 1, 2019, benefits under the Elevance Health Cash Balance Plan B were curtailed. All grandfathered participants no longer have pay credits added to their accounts but continue to earn interest on existing account balances. Participants continue to earn years of pension service for vesting purposes. Several pension plans acquired through various corporate mergers and acquisitions were merged into these plans in prior years.

The Employees' Retirement Plan of Blue Cross of California (the "BCC Plan") is a defined benefit pension plan that covers eligible employees of Blue Cross of California who are covered by a collective bargaining agreement. Effective January 1, 2007, benefits were curtailed under the BCC Plan with the result that no Blue Cross of California employees hired or rehired after December 31, 2006 are eligible to participate in the BCC Plan.

All of the plans' assets consist primarily of equity securities, fixed maturity securities, investment funds and cash. The funding policies for all plans are to contribute amounts at least sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as further amended by the Pension Protection Act of 2006, and in accordance with income tax regulations, plus such additional amounts as are necessary to provide assets sufficient to meet the benefits to be paid to plan participants.

The following tables disclose consolidated "pension benefits," which include the defined benefit pension plans described above, and consolidated "other benefits," which include postretirement health and welfare benefits including medical, vision and dental benefits offered to certain employees. Calculations were computed using assumptions at the December 31 measurement dates.

The reconciliation of the benefit obligation is as follows:

	Pension Benefits		Other Benefits	
	2022	2021	2022	2021
Benefit obligation at beginning of year	$ 1,859	$ 2,009	$ 343	$ 399
Service cost	—	—	—	1
Interest cost	52	34	7	5
Plan participant contributions	—	—	17	17
Actuarial (gain) loss	(362)	(33)	(54)	(31)
Settlements	(74)	(90)	—	—
Benefits paid	(60)	(61)	(36)	(48)
Benefit obligation at end of year	$ 1,415	$ 1,859	$ 277	$ 343

The changes in the fair value of plan assets are as follows:

	Pension Benefits		Other Benefits	
	2022	2021	2022	2021
Fair value of plan assets at beginning of year	$ 2,216	$ 2,186	$ 371	$ 391
Actual return on plan assets	(352)	174	(61)	33
Employer contributions	4	7	—	—
Plan participant contributions	—	—	17	17
Settlements	(74)	(90)	—	(29)
Benefits paid	(60)	(61)	(28)	(41)
Fair value of plan assets at end of year	$ 1,734	$ 2,216	$ 299	$ 371

The net amount included in the consolidated balance sheets is as follows:

	Pension Benefits		Other Benefits	
	2022	2021	2022	2021
Noncurrent assets	$ 363	$ 415	$ 22	$ 28
Current liabilities	(6)	(6)	—	—
Noncurrent liabilities	(38)	(52)	—	—
Net amount at December 31	$ 319	$ 357	$ 22	$ 28

The net amounts included in accumulated other comprehensive income (loss) that have not been recognized as components of net periodic benefit costs are as follows:

	Pension Benefits		Other Benefits	
	2022	2021	2022	2021
Net actuarial (loss) gain	$ (672)	$ (625)	$ 5	$ 36
Prior service credit	—	—	3	8
Net amount before tax at December 31	$ (672)	$ (625)	$ 8	$ 44

The accumulated benefit obligation for the defined benefit pension plans was $1,413 and $1,857 at December 31, 2022 and 2021, respectively.

As of December 31, 2022, certain pension plans had accumulated benefit obligations in excess of plan assets. Such plans had accumulated benefit obligation and fair value of plan assets of $44 and $0, respectively. In addition, certain plans had projected benefit obligations in excess of plan assets. Such plans had projected benefit obligation and fair value of plan assets of $44 and $0, respectively.

The weighted-average assumptions used in calculating the benefit obligations for all plans are as follows:

	Pension Benefits		Other Benefits	
	2022	2021	2022	2021
Discount rate	5.18 %	2.70 %	5.12 %	2.49 %
Rate of compensation increase	3.00 %	3.00 %	3.00 %	3.00 %
Expected rate of return on plan assets	6.58 %	5.02 %	6.57 %	6.43 %
Interest crediting rate	4.25 %	3.82 %	3.89 %	1.56 %

The components of net periodic benefit credit included in the consolidated statements of income are as follows:

	2022	2021	2020
Pension Benefits			
Interest cost	$ 52	$ 34	$ 47
Expected return on assets	(101)	(134)	(138)
Recognized actuarial loss	16	25	24
Settlement loss	28	26	29
Net periodic benefit credit	$ (5)	$ (49)	$ (38)
Other Benefits			
Service cost	$ —	$ 1	$ 1
Interest cost	7	5	10
Expected return on assets	(26)	(26)	(25)
Amortization of prior service credit	(4)	(4)	(7)
Net periodic benefit credit	$ (23)	$ (24)	$ (21)

During the years ended December 31, 2022, 2021 and 2020, we incurred total settlement losses of $28, $26 and $29, respectively, as lump-sum payments exceeded the service cost and interest cost components of net periodic benefit cost for certain of our plans.

The weighted-average assumptions used in calculating the net periodic benefit cost for all plans are as follows:

	2022	2021	2020
Pension Benefits			
Discount rate	2.70 %	2.24 %	3.11 %
Rate of compensation increase	3.00 %	3.00 %	3.00 %
Expected rate of return on plan assets	5.02 %	6.72 %	7.33 %
Interest crediting rate	3.82 %	3.82 %	3.82 %
Other Benefits			
Discount rate	2.49 %	1.99 %	2.93 %
Rate of compensation increase	3.00 %	3.00 %	3.00 %
Expected rate of return on plan assets	6.43 %	6.60 %	7.00 %
Interest crediting rate	1.56 %	0.87 %	1.81 %

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2022 measurement date was 8.00% for 2023, with a gradual decline to 4.50% by the year 2035. The assumed healthcare cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2022 measurement date was 6.50% for 2023, with a gradual decline to 4.50% by the year 2035. These estimated trend rates are subject to change in the future.

Plan assets include a diversified mix of equity securities, investment grade fixed maturity securities and other types of investments across a range of sectors and levels of capitalization to maximize long-term return for a prudent level of risk. The weighted-average target allocation for pension benefit plan assets is 37% equity securities, 58% fixed maturity securities, and 5% to all other types of investments. Equity securities primarily include a mix of domestic securities, foreign securities and mutual funds invested in equities. Fixed maturity securities primarily include treasury securities, corporate bonds and asset-backed investments issued by corporations and the U.S. government. Other types of investments include insurance contracts

designed specifically for employee benefit plans, a commingled fund comprised primarily of equity securities and certain partnership interests.

The partnerships hold various types of underlying assets such as real estate and investments in oil and gas companies. Generally, the partnership interests are not redeemable and are transferable only with the consent of the general partner. Unfunded commitments related to all partnership interests totaled approximately $2 and $3 at December 31, 2022 and 2021, respectively.

As of December 31, 2022, there were no significant concentrations of investments in the pension benefit assets or other benefit assets. No plan assets were invested in Elevance Health common stock.

Pension benefit assets and other benefit assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value.

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2022, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of $36, and excluding estimated claims settlements to be paid from other benefit assets of ($17), are as follows (see Note 7, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2022				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	$ 489	$ —	$ —	$ 489
Foreign securities	145	—	—	145
Mutual funds	39	—	—	39
Fixed maturity securities:				
Government securities	—	247	—	247
Corporate securities	—	275	—	275
Asset-backed securities	—	185	—	185
Other types of investments:				
Commingled fund	—	93	—	93
Insurance company contracts	—	—	154	154
Total pension benefit assets at fair value	$ 673	$ 800	$ 154	1,627
Partnership investments				71
Total pension benefit assets				$ 1,698
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 7	$ —	$ —	$ 7
Foreign securities	1	—	—	1
Mutual funds	17	—	—	17
Fixed maturity securities:				
Government securities	—	3	—	3
Corporate securities	—	3	—	3
Asset-backed securities	—	3	—	3
Other types of investments:				
Commingled fund	—	2	—	2
Life insurance contracts	—	—	270	270
Investment in DOL 103-12 trust	—	10	—	10
Total other benefit assets	$ 25	$ 21	$ 270	$ 316

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2021, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of $48, and excluding estimated claims settlements to be paid from other benefit assets of ($29), are as follows:

	Level I	Level II	Level III	Total
December 31, 2021				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	$ 682	$ —	$ —	$ 682
Foreign securities	204	—	—	204
Mutual funds	49	—	—	49
Fixed maturity securities:				
Government securities	—	395	—	395
Corporate securities	—	379	—	379
Asset-backed securities	—	98	—	98
Other types of investments:				
Commingled fund	—	106	—	106
Insurance company contracts	—	—	179	179
Total pension benefit assets at fair value	$ 935	$ 978	$ 179	2,092
Partnership investments				78
Total pension benefit assets				$ 2,170
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 10	$ —	$ —	$ 10
Foreign securities	2	—	—	2
Mutual funds	24	—	—	24
Fixed maturity securities:				
Government securities	—	4	—	4
Corporate securities	—	4	—	4
Asset-backed securities	—	3	—	3
Other types of investments:				
Commingled fund	—	2	—	2
Life insurance contracts	—	—	338	338
Investment in DOL 103-12 trust	—	11	—	11
Total other benefit assets	$ 36	$ 24	$ 338	$ 398

A reconciliation of the beginning and ending balances of plan assets measured at fair value using Level III inputs for the years ended December 31, 2022, 2021 and 2020 is as follows:

	Insurance Company Contracts	Life Insurance Contracts	Total
Year ended December 31, 2022			
Beginning balance at January 1, 2022	$ 179	$ 338	$ 517
Actual return on plan assets relating to assets still held at the reporting date	(22)	(53)	(75)
Purchases	9	—	9
Sales	(12)	(15)	(27)
Ending balance at December 31, 2022	$ 154	$ 270	$ 424
Year ended December 31, 2021			
Beginning balance at January 1, 2021	$ 189	$ 323	$ 512
Actual return on plan assets relating to assets still held at the reporting date	(6)	26	20
Purchases	5	—	5
Sales	(9)	(11)	(20)
Ending balance at December 31, 2021	$ 179	$ 338	$ 517
Year ended December 31, 2020			
Beginning balance at January 1, 2020	$ 175	$ 294	$ 469
Actual return on plan assets relating to assets still held at the reporting date	7	29	36
Purchases	15	—	15
Sales	(8)	—	(8)
Ending balance at December 31, 2020	$ 189	$ 323	$ 512

There were no other transfers into or out of Level III during the years ended December 31, 2022, 2021 or 2020.

Our current funding strategy is to fund an amount at least equal to the minimum required funding as determined under ERISA with consideration of maximum tax deductible amounts. We may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes. For the years ended December 31, 2022, 2021 and 2020, no material contributions were necessary to meet ERISA required funding levels. However, during each of the years ended December 31, 2022, 2021 and 2020, we made tax deductible discretionary contributions to the pension benefit plans of $4, $7, and $7, respectively. Employer contributions to other benefit plans represent discretionary contributions and do not include payments to retirees for current benefits.

Our estimated future payments for pension benefits and other benefits, which reflect expected future service, as appropriate, are as follows:

	Pension Benefits	Other Benefits
2023	$ 125	$ 32
2024	120	30
2025	118	29
2026	116	28
2027	113	27
2028 - 2032	526	110

In addition to the defined benefit plans, we maintain the Elevance Health 401(k) Plan (formerly the Anthem 401(k) Plan), which is a qualified defined contribution plan covering substantially all employees. Voluntary employee contributions are matched by us subject to certain limitations. Contributions made by us totaled $275, $241 and $221 during 2022, 2021 and 2020, respectively.

12. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable for the years ended December 31, 2022, 2021 and 2020 is as follows:

	2022	2021	2020
Gross medical claims payable, beginning of year	$ 13,282	$ 11,135	$ 8,647
Ceded medical claims payable, beginning of year	(21)	(46)	(33)
Net medical claims payable, beginning of year	13,261	11,089	8,614
Business combinations and purchase adjustments	133	420	339
Net incurred medical claims:			
Current year	113,414	100,440	85,094
Prior years redundancies	(869)	(1,703)	(637)
Total net incurred medical claims	112,545	98,737	84,457
Net payments attributable to:			
Current year medical claims	98,997	88,156	74,629
Prior years medical claims	11,600	8,829	7,692
Total net payments	110,597	96,985	82,321
Net medical claims payable, end of year	15,342	13,261	11,089
Ceded medical claims payable, end of year	6	21	46
Gross medical claims payable, end of year	$ 15,348	$ 13,282	$ 11,135

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period-end are continually reviewed and re-estimated as information regarding actual claims payments, or runout, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of $869 shown above for the year ended December 31, 2022 represents an estimate based on paid claim activity from January 1, 2022 to December 31, 2022. Medical claim liabilities are usually described as having a “short tail,” which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the $869 redundancy relates to claims incurred in calendar year 2021.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2022, 2021 and 2020, which are the completion and trend factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. We had increased estimation uncertainty on our incurred but not reported liability at December 31, 2022 and December 31, 2021. Slowdowns in claims submission patterns and increases in utilization levels for COVID-19 testing and treatment are the primary factors that lead to the increased estimation uncertainty.

	Favorable Developments by Changes in Key Assumptions		
	2022	2021	2020
Assumed trend factors	$ (859)	$ (1,429)	$ (599)
Assumed completion factors	(10)	(274)	(38)
Total	$ (869)	$ (1,703)	$ (637)

The favorable development recognized in 2022 resulted primarily from trend factors in late 2021 developing more favorably than originally expected as well as a smaller contribution from completion factor development.

The favorable development recognized in 2021 resulted primarily from trend factors in late 2020 developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development.

The favorable development recognized in 2020 resulted primarily from trend factors in late 2019 developing more favorably than originally expected as well as a smaller contribution from completion factor development.

The reconciliation of net incurred medical claims to benefit expense included in the consolidated statements of income is as follows:

	Years Ended December 31		
	2022	2021	2020
Total net incurred medical claims	$ 112,545	$ 98,737	$ 84,457
Quality improvement and other claims expense	4,097	3,834	3,588
Benefit expense	$ 116,642	$ 102,571	$ 88,045

Incurred claims development, net of reinsurance, for the years ended December 31, 2022, 2021 and 2020 is as follows:

	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2020 (Unaudited)	2021 (Unaudited)	2022
2020 & Prior	$ 93,410	$ 91,708	$ 91,683
2021		100,860	100,016
2022			113,547
Total			$ 305,246

Paid claims development, net of reinsurance, for the years ended December 31, 2022, 2021 and 2020 is as follows:

	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2020 (Unaudited)	2021 (Unaudited)	2022
2020 & Prior	$ 82,322	$ 91,151	$ 91,488
2021		88,156	99,419
2022			98,997
Total			$ 289,904

At December 31, 2022, the total of incurred but not reported liabilities plus expected development on reported claims was $195, $597 and $14,550 for the claim years 2020 and prior, 2021 and 2022, respectively.

At December 31, 2022, the cumulative number of reported claims was 360, 440 and 404 for the claim years 2020 and prior, 2021 and 2022, respectively.

The information about incurred claims development, paid claims development and cumulative number of reported claims for the years ended December 31, 2020 and 2021 is unaudited and presented as supplementary information.

The cumulative number of reported claims for each claim year has been developed using historical data captured by our claim payment systems. The provided claim amounts are not a precise tool for understanding utilization of medical services. They could be impacted by a variety of factors, including changes in provider billing practices, provider reimbursement arrangements, mix of services, benefit design or processing systems. The cumulative number of reported claims has been provided to comply with FASB accounting standards and is not used by management in its claims analysis. Our cumulative number of reported claims may not be comparable to similar measures reported by other health benefits companies.

The reconciliation of incurred and paid claims development information for the three years ended December 31, 2022, reflected in the tables above, to the consolidated ending balance for medical claims payable included in the consolidated balance sheet, as of December 31, 2022, is as follows:

	Total
Cumulative incurred claims and allocated claim adjustment expenses, net of reinsurance	$ 305,246
Less: Cumulative paid claims and allocated claim adjustment expenses, net of reinsurance	289,904
Net medical claims payable, end of year	15,342
Ceded medical claims payable, end of year	6
Insurance lines other than short duration	248
Gross medical claims payable, end of year	$ 15,596

13. Debt

Short-term Borrowings

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York (collectively, the "FHLBs"). As a member we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2022 and 2021, $265 and $275, respectively, were outstanding under our short-term FHLB borrowings. Outstanding short-term FHLB borrowings at December 31, 2022 had fixed interest rates of 4.240%.

Through certain subsidiaries, we have entered into multiple 364-day lines of credit (the "Subsidiary Credit Facilities") with separate lenders for general corporate purposes. The Subsidiary Credit Facilities provide combined credit of up to $200. The interest rate on each line of credit is based on the LIBOR rate plus a predetermined rate. Our ability to borrow under the lines of credit is subject to compliance with certain covenants. At each of December 31, 2022 and 2021, $0 was outstanding under our Subsidiary Credit Facilities.

Long-term Debt

The carrying value of our long-term debt at December 31, 2022 and 2021 consists of the following:

	2022	2021
Senior unsecured notes:		
2.950%, due 2022	$ —	$ 749
3.125%, due 2022	—	850
3.300%, due 2023	1,000	1,014
0.450%, due 2023	500	499
3.350%, due 2024	849	848
3.500%, due 2024	798	797
2.375%, due 2025	1,252	1,253
5.350%, due 2025	398	—
1.500%, due 2026	746	745
3.650%, due 2027	1,592	1,592
4.101%, due 2028	1,234	1,251
2.875%, due 2029	820	820
2.250%, due 2030	1,071	1,089
2.550%, due 2031	968	992
4.100%, due 2032	595	—
5.500%, due 2032	644	—
5.950%, due 2034	334	334
5.850%, due 2036	396	396
6.375%, due 2037	364	364
5.800%, due 2040	114	114
4.625%, due 2042	859	859
4.650%, due 2043	974	974
4.650%, due 2044	767	767
5.100%, due 2044	548	548
4.375%, due 2047	1,388	1,387
4.550%, due 2048	840	839
3.700%, due 2049	812	812
3.125%, due 2050	988	987
3.600%, due 2051	1,233	1,232
4.550%, due 2052	689	—
6.100%, due 2052	741	—
4.850%, due 2054	247	247
Surplus note:		
9.000%, due 2027	25	25
Senior convertible debentures:		
2.750%, due 2042	63	72
Variable rate debt:		
Commercial paper program	—	300
Total long-term debt	23,849	22,756
Current portion of long-term debt	(1,500)	(1,599)
Long-term debt, less current portion	$ 22,349	$ 21,157

All debt is a direct obligation of Elevance Health, Inc., except for the surplus note, the FHLB borrowings and the Subsidiary Credit Facilities.

We generally issue senior unsecured notes ("Notes") for long-term borrowing purposes. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating.

On February 8, 2023, we issued $500 aggregate principal amount of 4.900% Notes due 2026 (the "2026 Notes"), $1,000 aggregate principal amount of 4.750% Notes due 2033 (the "2033 Notes"), and $1,100 aggregate principal amount of 5.125% Notes due 2053 (the "2053 Notes") under our shelf registration statement. Interest on the 2026 Notes is payable semi-annually in arrears on February 8 and August 8 of each year, commencing August 8, 2023. Interest on the 2033 Notes and 2053 Notes is payable semi-annually in arrears on February 15 and August 15 of each year, commencing August 15, 2023. We intend to use the proceeds for working capital and general corporate purposes, including, but not limited to, the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

On December 1, 2022, we repaid, at maturity, the $750 outstanding balance of our 2.950% senior unsecured notes.

On November 4, 2022, we issued $400 aggregate principal amount of 5.350% Notes due 2025, $650 aggregate principal amount of 5.500% Notes due 2032 and $750 aggregate principal amount of 6.100% Notes due 2052 under our shelf registration statement. Interest on these notes is payable semi-annually in arrears on April 15 and October 15 of each year, commencing April 15, 2023. We used the net proceeds for working capital and general corporate purposes, such as the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

On May 16, 2022, we repaid, at maturity, the $850 outstanding balance of our 3.125% senior unsecured notes.

On April 29, 2022, we issued $600 aggregate principal amount of 4.100% Notes due 2032 and $700 aggregate principal amount of 4.550% Notes due 2052 under our shelf registration statement. Interest on these notes is payable semi-annually in arrears on May 15 and November 15 of each year, commencing November 15, 2022. We used the net proceeds for working capital and general corporate purposes, such as the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

On May 15, 2021, we redeemed the $700 outstanding principal balance of our 3.700% Notes due August 15, 2021 at a redemption price equal to 100% of the aggregate principal amount of the notes being redeemed, plus accrued and unpaid interest.

On March 17, 2021, we issued $500 aggregate principal amount of 0.450% Notes due 2023, $750 aggregate principal amount of 1.500% Notes due 2026, $1,000 aggregate principal amount of 2.550% Notes due 2031 and $1,250 aggregate principal amount of 3.600% Notes due 2051 under our shelf registration statement. Interest on these notes is payable semiannually in arrears on March 15 and September 15 of each year, commencing September 15, 2021. We used the net proceeds for working capital and general corporate purposes, such as the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

Additionally, during the year ended December 31, 2021, we repurchased $52 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium for early redemption plus accrued and unpaid interest, for cash totaling $67. We recognized a loss on extinguishment of debt of $15 for the repurchase of these notes.

On November 23, 2020, we repaid, at maturity, the $900 outstanding balance of our 2.500% senior unsecured notes. On August 17, 2020, we repaid, at maturity, the $700 outstanding balance of our 4.350% senior unsecured notes.

Additionally, during the year ended December 31, 2020, we repurchased $79 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium for early redemption plus accrued and unpaid interest, for cash totaling $109. We recognized a loss on extinguishment of debt of $30 for the repurchase of these notes.

On May 5, 2020, we issued $400 aggregate principal amount of additional senior notes pursuant to a reopening of our existing 2.375% Notes due 2025 (the "2025 Notes"), $1,100 aggregate principal amount of 2.250% Notes due 2030 (the "2030 Notes"), and $1,000 aggregate principal amount of 3.125% Notes due 2050 (the "2050 Notes") under our shelf

registration statement. The 2025 Notes constitute an additional issuance of our 2.375% notes due 2025, of which $850 aggregate principal amount was issued on September 9, 2019. Interest on the 2025 Notes is deemed to have accrued from January 15, 2020 and is payable semi-annually in arrears on January 15 and July 15 of each year, commencing July 15, 2020. Interest on the 2030 Notes and 2050 Notes is payable semi-annually in arrears on May 15 and November 15 of each year, commencing November 15, 2020. The proceeds were used for working capital and general corporate purposes, such as the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

The surplus note is an unsecured obligation of Anthem Insurance Companies, Inc. ("Anthem Insurance"), a wholly owned subsidiary, and is subordinate in right of payment to all of Anthem Insurance's existing and future indebtedness. Any payment of interest or principal on the surplus note may be made only with the prior approval of the Indiana Department of Insurance ("IDOI") and only out of capital and surplus funds of Anthem Insurance that the IDOI determines to be available for the payment under Indiana insurance laws.

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. On April 18, 2022, we amended and restated the credit agreement for the 5-Year Facility to, among other things, extend the maturity date of the 5-Year Facility from June 2024 to April 2027 and increase the amount of credit available under the 5-Year Facility from $2,500 to $4,000. Also on April 18, 2022, concurrently with the amendment and restatement of the 5-Year Facility, we terminated our 364-day senior revolving credit facility that provided for credit in the amount of $1,000, which was scheduled to mature in June 2022 (the "2021 364-Day Facility"). In June 2021, we terminated our 364-day senior revolving credit facility (the "prior 364-Day Facility"), which was scheduled to mature in June 2021, and entered into the 2021 364-Day Facility with a group of lenders for general corporate purposes. Our ability to borrow under the 5-Year Facility is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the credit agreement for the 5-Year Facility. As of December 31, 2022, our debt-to-capital ratio, as defined and calculated under the 5-Year Facility, was 39.9%. We do not believe the restrictions contained in our 5-Year Facility covenants materially affect our financial or operating flexibility. As of December 31, 2022, we were in compliance with all of our debt covenants under the 5-Year Facility. There were no amounts outstanding under the 5-Year Facility, the 2021 364-Day Facility or the prior 364-Day Facility at any time during the years ended December 31, 2022 or 2021.

We have an authorized commercial paper program of up to $4,000, the proceeds of which may be used for general corporate purposes. In July 2022, we increased the amount available under the commercial paper program from $3,500 to $4,000. At December 31, 2022, we had $0 outstanding under our commercial paper program. At December 31, 2021, we had $300 outstanding under our commercial paper program with a weighted-average interest rate of 0.150%. Commercial paper borrowings have been classified as long-term debt at December 31, 2022 and 2021, as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year, and we have the ability to redeem our commercial paper with borrowings under the credit facilities described above.

Convertible Debentures

On October 9, 2012, we issued $1,500 of senior convertible debentures (the "Debentures") in a private offering to qualified institutional buyers pursuant to Rule 144A under the Securities Act of 1933, as amended (the "Securities Act"). The Debentures are governed by an indenture dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Indenture"). The Debentures bear interest at a rate of 2.750% per year, payable semi-annually in arrears in cash on April 15 and October 15 of each year, and mature on October 15, 2042, unless earlier redeemed, repurchased or converted into shares of common stock at the applicable conversion rate. The Debentures also have a contingent interest feature that requires us to pay additional interest based on certain thresholds and for certain events, as defined in the Indenture, beginning on October 15, 2022. As of October 15, 2022, one of these events had occurred and contingent interest began accruing on the Debentures at a rate of 0.50% of the average trading price of a Debenture for the ten consecutive trading days ended October 14, 2022. Contingent interest will be payable on April 15, 2023, to holders of the Debentures as of the April 1, 2023 record date.

Holders may convert their Debentures at their option prior to the close of business on the business day immediately preceding April 15, 2042, only under the following circumstances: (1) during any fiscal quarter if the last reported sale price of our common stock for at least 20 trading days during a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter is greater than or equal to 130% of the applicable conversion price on each applicable trading

day; (2) during the five business day period after any 10 consecutive trading day period (the "measurement period") in which the trading price per $1,000 (whole dollars) principal amount of Debentures for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the applicable conversion rate on each such day; (3) if we call any or all of the Debentures for redemption, at any time prior to the close of business on the business day immediately preceding the redemption date; or (4) upon the occurrence of specified corporate events, as defined in the Indenture. On and after April 15, 2042 and until the close of business on the third scheduled trading day immediately preceding the Debentures' maturity date of October 15, 2042, holders may convert their Debentures into common stock at any time irrespective of the preceding circumstances. The Debentures are redeemable at our option at any time on or after October 20, 2022, upon the occurrence of certain events, as defined in the Indenture.

On February 13, 2023, we delivered notice to redeem all of the outstanding Debentures. The Debentures will be redeemed on March 15, 2023 at a redemption price equal to 100% of the principal amount of the Debentures plus accrued and unpaid interest to, but excluding, the date of redemption.

Upon conversion of the Debentures, we will deliver cash up to the aggregate principal amount of the Debentures converted. With respect to any conversion obligation in excess of the aggregate principal amount of the Debentures converted, we have the option to settle the excess with cash, shares of our common stock or a combination thereof based on a daily conversion value, determined in accordance with the Indenture. The initial conversion rate for the Debentures was 13.2319 shares of our common stock per Debenture, which represented a 25% conversion premium based on the closing price of $60.46 per share of our common stock on October 2, 2012 (the date the Debentures' terms were finalized) and is equivalent to an initial conversion price of $75.575 per share of our common stock.

During the year ended December 31, 2022, $41 aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the conversion with cash for total payments of $299. During the year ended December 31, 2021, $54 aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the conversions with cash for total payments of $302. We recognized a loss on the extinguishment of debt related to the Debentures of $6, based on the fair values of the debt on the conversion settlement dates. During the year ended December 31, 2020, $56 aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the conversions with cash for total payments of $222. We recognized a loss on the extinguishment of debt related to the Debentures of $6, based on the fair values of the debt on the conversion settlement dates.

As of December 31, 2022, our common stock was last traded at a price of $512.97 per share. If the remaining Debentures had been converted or matured at December 31, 2022, we would have been obligated to pay the principal of the Debentures plus an amount in cash or shares equal to $402. The Debentures and underlying shares of our common stock have not been and will not be registered under the Securities Act, or any state securities laws, and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

We accounted for the Debentures in accordance with the FASB cash conversion guidance for debt with conversion and other options at the time of issue. As a result, the value of the embedded conversion option, net of deferred taxes and equity issuance costs, was bifurcated from its debt host and recorded as a component of additional paid-in capital in our consolidated balance sheets. We adopted ASU 2020-06 on January 1, 2022 using the modified retrospective transition method, which resulted in an increase to our reported debt outstanding of $31, a decrease of our deferred tax liabilities of $8 and a corresponding cumulative-effect reduction to our opening retained earnings of $23, eliminating the bifurcation of the embedded conversion option.

The following table summarizes, at December 31, 2022, the related balances, conversion rate and conversion price of the Debentures:

Outstanding principal amount	$	63
Net debt carrying amount	$	63
Conversion rate (shares of common stock per $1,000 of principal amount)		14.3238
Effective conversion price (per $1,000 of principal amount)	$	69.8139

During the years ended December 31, 2022, 2021 and 2020, we recognized $2, $4 and $6, respectively, of interest expense related to the Debentures, of which $2, $3 and $5, respectively, represented interest expense recognized at the stated interest rate of 2.750% and $0, $1 and $1, respectively, represented interest expense resulting from amortization of the debt discount.

Interest paid on our total outstanding debt during 2022, 2021 and 2020 was $878, $822, and $794, respectively.

We were in compliance with all applicable covenants under all of our outstanding debt agreements at December 31, 2022 and 2021.

Future maturities of all long-term debt outstanding at December 31, 2022 are as follows: 2023, $1,500; 2024, $1,647; 2025, $1,650; 2026, $746; 2027, $1,592 and thereafter, $16,714.

14. Commitments and Contingencies

Litigation and Regulatory Proceedings

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves is, in the aggregate, from $0 to approximately $250 at December 31, 2022. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Blue Cross Blue Shield Antitrust Litigation

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA and Blue Cross and/or Blue Shield licensees (the "Blue plans") across the country. Cases filed in twenty-eight states were consolidated into a single, multi-district proceeding captioned *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the U.S. District Court for the Northern District of Alabama (the "Court"). Generally, the suits allege that the BCBSA and the Blue plans have conspired to horizontally allocate geographic markets through license agreements, best efforts rules that limit the percentage of non-Blue revenue of each plan, restrictions on acquisitions, rules governing the BlueCard® and National Accounts programs and other arrangements in violation of the Sherman Antitrust Act ("Sherman Act") and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers.

In April 2018, the Court issued an order on the parties' cross motions for partial summary judgment, determining that the defendants' aggregation of geographic market allocations and output restrictions are to be analyzed under a per se standard of review, and the BlueCard® program and other alleged Section 1 Sherman Act violations are to be analyzed under the rule of reason standard of review. With respect to whether the defendants operate as a single entity with regard to the enforcement of the Blue Cross Blue Shield trademarks, the Court found that summary judgment was not appropriate due to the existence of genuine issues of material fact. In April 2019, the plaintiffs filed motions for class certification, which defendants opposed.

The BCBSA and Blue plans approved a settlement agreement and release with the subscriber plaintiffs (the "Subscriber Settlement Agreement"), which agreement required the Court's approval to become effective. The Subscriber Settlement Agreement requires the defendants to make a monetary settlement payment and contains certain terms imposing non-monetary obligations including (i) eliminating the "national best efforts" rule in the BCBSA license agreements (which rule limits the percentage of non-Blue revenue permitted for each Blue plan) and (ii) allowing for some large national employers with self-funded benefit plans to request a bid for insurance coverage from a second Blue plan in addition to the local Blue plan.

In November 2020, the Court issued an order preliminarily approving the Subscriber Settlement Agreement, following which members of the subscriber class were provided notice of the Subscriber Settlement Agreement and an opportunity to opt out of the class. A small number of subscribers submitted valid opt-outs by the July 2021 opt-out deadline. A fairness hearing was held in October 2021 and the Court took the request for final approval under advisement. In February 2022, the Court ordered the issuance of a supplemental notice to self-funded account class members. The notice process was completed in March 2022.

In August 2022, the Court issued a final order approving the Subscriber Settlement Agreement (the "Final Approval Order"). The Court amended its Final Approval Order in September 2022, further clarifying the injunctive relief that may be available to subscribers who submitted valid opt-outs. In September 2022, an objector filed a motion to amend the Final Approval Order, which the Court denied. In compliance with the Subscriber Settlement Agreement, the Company paid $506 into an escrow account in September 2022, for an aggregate and full settlement payment by the Company of $596, which was previously accrued in 2020.

Four notices of appeal of the Final Approval Order were filed by the September 2022 appeal deadline. Those appeals are proceeding in the United States Court of Appeals for the Eleventh Circuit. In the event that all appellate rights are exhausted in a manner that affirms the Court's Final Approval Order, the defendants' payment and non-monetary obligations under the Subscriber Settlement Agreement will become effective and the funds held in escrow will be distributed in accordance with the Subscriber Settlement Agreement.

In October 2020, after the Court lifted the stay as to the provider litigation, provider plaintiffs filed a renewed motion for class certification, which defendants opposed. In March 2021, the Court issued an order terminating the pending motion for class certification until the Court determines the standard of review applicable to the providers' claims. In May 2021, the defendants and provider plaintiffs filed renewed standard of review motions. In June 2021, the parties filed summary judgment motions not critically dependent on class certification. In February 2022, the Court issued orders (i) granting certain defendants' motion for partial summary judgment against the provider plaintiffs who had previously released claims against such defendants, and (ii) granting the provider plaintiffs' motion for partial summary judgment, holding that *Ohio v. American Express Co*. does not affect the standard of review in this case. In August 2022, the Court issued orders (i) granting in part the defendants' motion regarding the antitrust standard of review, holding that for the period of time after the elimination of the "national best efforts" rule, the rule of reason applies to the provider plaintiffs' market allocation conspiracy claims, and (ii) denying the provider plaintiffs' motion for partial summary judgment on the standard of review, reaffirming its prior holding that the providers' group boycott claims are subject to the rule of reason. In November 2022, the Court issued an order requiring the parties to submit supplemental briefs on certain questions related to providers' renewed motion for class certification. We intend to continue to vigorously defend the provider litigation, which we believe is without merit; however, its ultimate outcome cannot be presently determined.

A number of follow-on cases involving entities that opted out of the Subscriber Settlement Agreement have been filed. Those actions are: *Alaska Air Group, Inc., et al. v. Anthem, Inc., et al.,* No. 2:21-cv-01209-AMM (N.D. Ala.); *JetBlue Airways Corp., et al. v. Anthem, Inc., et al.*, No. 2:22-cv-00558-GMB (N.D. Ala.); *Metropolitan Transportation Authority v. Blue Cross and Blue Shield of Alabama et al.*, No. 2:22-cv-00265-RDP (N.D. Ala.); *Bed Bath & Beyond Inc. v. Anthem, Inc.*, No. 2:22-cv-01256-SGC (N.D. Ala.); *Hoover, et al. v. Blue Cross Blue Shield Association, et al.*, No. 2:22-cv-00261-RDP (N.D. Ala.); and *VHS Liquidating Trust v. Blue Cross of California, et al.*, No. RG21106600 (Cal. Super.). We intend to continue to vigorously defend these follow-on cases, which we believe are without merit; however, their ultimate outcome cannot be presently determined.

Blue Cross of California Taxation Litigation

In July 2013, our California affiliate Blue Cross of California (doing business as Anthem Blue Cross) ("BCC") was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court (the "Superior Court") captioned *Michael D. Myers v. State Board of Equalization, et al.* This action was brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that BCC, a licensed Health Care Service Plan, is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. At the time, under California law, "insurers" were required to pay a gross premiums tax ("GPT") calculated as 2.35% on gross premiums. As a licensed Health Care Service Plan, BCC has paid the California Corporate Franchise Tax ("CFT"), the tax paid by California businesses generally.

Plaintiff contends that BCC must pay the GPT rather than the CFT and seeks a writ of mandate directing the taxing agencies to collect the GPT and an order requiring BCC to pay GPT back taxes, interest, and penalties for the eight-year period prior to the filing of the complaint.

Because the GPT is constitutionally imposed in lieu of certain other taxes, BCC has filed protective tax refund claims with the City of Los Angeles, the California Department of Health Care Services and the Franchise Tax Board to protect its rights to recover certain taxes previously paid should BCC eventually be determined to be subject to the GPT for the tax periods at issue in the litigation.

In March 2018, the Superior Court denied BCC's motion for judgment on the pleadings and similar motions brought by other entities. In December 2020, the Superior Court granted BCC's motion for summary judgment, dismissing the plaintiff's lawsuit. In November 2021, the plaintiff appealed the summary judgment order. BCC's responding brief was filed in March 2022 and Plaintiff's reply was filed in May 2022. We estimate that the appeal will be heard in March 2023. We intend to vigorously defend the appeal of this lawsuit.

Express Scripts, Inc. Pharmacy Benefit Management Litigation

In March 2016, we filed a lawsuit against Express Scripts, Inc. ("Express Scripts"), our vendor at the time for PBM services, captioned *Anthem, Inc. v. Express Scripts, Inc.*, in the U.S. District Court for the Southern District of New York (the "District Court"). The lawsuit seeks to recover over $14,800 in damages for pharmacy pricing that is higher than competitive benchmark pricing under the agreement between the parties (the "ESI PBM Agreement"), over $158 in damages related to operational breaches, as well as various declarations under the ESI PBM Agreement, including that Express Scripts: (i) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (ii) was required to provide competitive benchmark pricing to us through the term of the ESI PBM Agreement; (iii) has breached the ESI PBM Agreement; and (iv) is required under the ESI PBM Agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination.

Express Scripts has disputed our contractual claims and is seeking declaratory judgments: (i) regarding the timing of the periodic pricing review under the ESI PBM Agreement, and (ii) that it has no obligation to ensure that we receive any specific level of pricing, that we have no contractual right to any change in pricing under the ESI PBM Agreement and that its sole obligation is to negotiate proposed pricing terms in good faith. In the alternative, Express Scripts claims that we have been unjustly enriched by its payment of $4,675 at the time we entered into the ESI PBM Agreement. In March 2017, the District Court granted our motion to dismiss Express Scripts' counterclaims for (i) breach of the implied covenant of good faith and fair dealing, and (ii) unjust enrichment with prejudice. After such ruling, Express Scripts' only remaining claims were for breach of contract and declaratory relief. In August 2021, Express Scripts filed a motion for summary judgment, which we opposed. In March 2022, the District Court granted in part and denied in part Express Scripts' motion for summary judgment. The District Court dismissed our declaratory judgment claim, our breach of contract claim for failure to prove damages and most of our operational breach claims. As a result of the summary judgment decision, the only remaining claims as of the filing of our 2022 Form 10-K are (i) our operational breach claim based on Express Scripts' prior authorization processes and (ii) Express Scripts' counterclaim for breach of the market check provision of the ESI PBM Agreement. Express Scripts filed a second motion for summary judgment in June 2022, challenging our remaining operational breach claims, which we opposed in July 2022. We intend to appeal the earlier summary judgment decision at the appropriate time, vigorously pursue our claims and defend against counterclaims, which we believe are without merit; however, the ultimate outcome of this litigation cannot be presently determined.

Medicare Risk Adjustment Litigation

In March 2020, the U.S. Department of Justice ("DOJ") filed a civil lawsuit against Elevance Health, Inc. (f/k/a Anthem, Inc.) in the U.S. District Court for the Southern District of New York (the "New York District Court") in a case captioned *United States v. Anthem, Inc*. The DOJ's suit alleges, among other things, that we falsely certified the accuracy of the diagnosis data we submitted to the Centers for Medicare and Medicaid Services ("CMS") for risk-adjustment purposes under Medicare Part C and knowingly failed to delete inaccurate diagnosis codes. The DOJ further alleges that, as a result of these purported acts, we caused CMS to calculate the risk-adjustment payments based on inaccurate diagnosis information, which enabled us to obtain unspecified amounts of payments in Medicare funds in violation of the False Claims Act. The DOJ filed an amended complaint in July 2020, alleging the same causes of action but revising some of its factual allegations. In

September 2020, we filed a motion to transfer the lawsuit to the Southern District of Ohio, a motion to dismiss part of the lawsuit, and a motion to strike certain allegations in the amended complaint. In an opinion and order issued October 3, 2022, the New York District Court denied our motions, and the case will now proceed in that court. In November 2022, we filed an answer. We intend to continue to vigorously defend this suit, which we believe is without merit; however, the ultimate outcome cannot be presently determined.

Investigations of CareMore and HealthSun

With the assistance of outside counsel, we are conducting investigations of risk-adjustment practices involving data submitted to CMS (unrelated to our retrospective chart review program) at CareMore Health Plans, Inc. ("CareMore"), one of our California subsidiaries, and HealthSun Health Plans, Inc. ("HealthSun"), one of our Florida subsidiaries. Our CareMore investigation has resulted in the termination of CareMore's relationship with one contracted provider in California. Our HealthSun investigation has focused on risk adjustment practices initiated prior to our acquisition of HealthSun in December 2017 that continued after the acquisition. We have voluntarily self-disclosed the existence of both of our investigations to CMS and the Criminal and Civil Divisions of the DOJ. We are cooperating with the ongoing investigations of the Criminal and Civil Divisions of the DOJ related to these risk adjustment practices, and have entered into a tolling agreement with the Civil Division of the DOJ related to its investigation. We are analyzing the scope of potential data corrections to be submitted to CMS and have begun to submit data corrections to CMS. We have also asserted indemnity claims for escrowed funds under the HealthSun purchase agreement for, among other things, breach of healthcare and financial representation provisions, based on the conduct discovered during our investigation. While certain elements of the escrow claims were resolved in the fourth quarters of 2021 and 2022, litigation in the Delaware Court of Chancery related to the remaining indemnity claims for escrowed funds remains ongoing.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like Health Maintenance Organizations ("HMOs") and health insurers generally, exclude certain healthcare and other services from coverage under our HMO, Preferred Provider Organizations and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable reimbursement of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

Contractual Obligations and Commitments

In March 2020, we entered into an agreement with a vendor for information technology infrastructure and related management and support services through June 2025. The new agreement supersedes certain prior agreements for such services and includes provisions for additional services not provided under those agreements. Our remaining commitment under this agreement at December 31, 2022 is approximately $761. We will have the ability to terminate the agreement upon the occurrence of certain events, subject to early termination fees.

In the second quarter of 2019, we began using our pharmacy benefits manager CarelonRx, formerly known as IngenioRx, to market and offer PBM services to our affiliated health plan customers, as well as to external customers outside of the health plans we own. The comprehensive PBM services portfolio includes, but is not limited to, formulary management, pharmacy networks, prescription drug database, member services and mail order capabilities. CarelonRx delegates certain PBM administrative functions, such as claims processing and prescription fulfillment, to CaremarkPCS

Health, L.L.C., which is a subsidiary of CVS Health Corporation, pursuant to a five-year agreement, which is set to terminate on December 31, 2024. With CarelonRx, we retain the responsibilities for clinical and formulary strategy and development, member and employer experiences, operations, sales, marketing, account management and retail network strategy.

Vulnerability from Concentrations

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash equivalents, investment securities, premium receivables and instruments held through hedging activities. All investment securities are managed by professional investment managers within policies authorized by our Board of Directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premium receivables are limited due to the large number of employer groups that constitute our customer base in the states in which we conduct business. As of December 31, 2022, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

15. Capital Stock

Stock Incentive Plans

Our Board of Directors has adopted the 2017 Elevance Health Incentive Compensation Plan, formerly known as the 2017 Anthem Incentive Compensation Plan ("2017 Incentive Plan"), which has been approved by our shareholders. The term of the 2017 Incentive Plan is such that no awards may be granted on or after May 18, 2027. The 2017 Incentive Plan gives authority to the Compensation Committee of the Board of Directors to make incentive awards to our non-employee directors, employees and consultants, consisting of stock options, stock, restricted stock, restricted stock units, cash-based awards, stock appreciation rights, performance shares and performance units. The 2017 Incentive Plan limits the number of available shares for issuance to 37.5 shares, subject to adjustment as set forth in the 2017 Incentive Plan.

Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the grant date. Stock options vest over three years in equal annual installments and generally have a term of ten years from the grant date.

Certain option grants contain provisions whereby the employee continues to vest in the award subsequent to termination due to retirement. Our attribution method for newly granted awards considers all vesting and other provisions, including retirement eligibility, in determining the requisite service period over which the fair value of the awards will be recognized.

Awards of restricted stock or restricted stock units are issued at the fair value of the stock on the grant date and may also include one or more performance measures that must be met for the award to vest. For restricted stock or restricted stock units without performance measures, the restrictions lapse in three equal annual installments. Restricted stock or restricted stock units with performance measures vest in three year installments. Performance units issued in 2022 will vest in 2025, based on certain revenue and earnings targets over the three year period of 2022 to 2024. Performance units issued in 2021 will vest in 2024, based on certain revenue and earnings targets over the three year period of 2021 to 2023. Performance units issued in 2020 will vest in 2023, based on certain revenue and earnings targets over the three year period of 2020 to 2022.

For the years ended December 31, 2022, 2021 and 2020, we recognized share-based compensation expense of $264, $255 and $283, respectively, as well as related tax benefits of $66, $65 and $74, respectively.

A summary of stock option activity for the year ended December 31, 2022 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2022	2.9	$ 255.50		
Granted	0.5	452.67		
Exercised	(0.5)	242.79		
Forfeited or expired	(0.1)	339.20		
Outstanding at December 31, 2022	2.8	293.28	6.35	$ 622
Exercisable at December 31, 2022	1.6	239.89	5.14	$ 448

The intrinsic value of options exercised during the years ended December 31, 2022, 2021 and 2020 amounted to $120, $121 and $147, respectively. We recognized tax benefits of $31, $32 and $40 during the years ended December 31, 2022, 2021 and 2020, respectively, from option exercises and disqualifying dispositions. During the years ended December 31, 2022, 2021 and 2020, we received cash of $120, $148 and $129, respectively, from exercises of stock options.

The total fair value of restricted stock awards that vested during the years ended December 31, 2022, 2021 and 2020 was $261, $287 and $335, respectively.

A summary of the status of nonvested restricted stock activity, including restricted stock units and performance units, for the year ended December 31, 2022 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2022	1.3	$ 299.65
Granted	0.6	453.70
Vested	(0.6)	301.89
Forfeited	(0.1)	347.73
Nonvested at December 31, 2022	1.2	357.21

During the year ended December 31, 2022, we granted approximately 0.2 restricted stock units that are contingent upon us achieving certain revenue and earnings targets over the three year period of 2022 to 2024. These grants have been included in the activity shown above, but will be subject to adjustment at the end of 2024, based on results in the three year period.

As of December 31, 2022, the total remaining unrecognized compensation expense related to nonvested stock options and restricted stock, including restricted stock units and performance units, amounted to $35 and $176, respectively, which will be amortized over the weighted-average remaining requisite service periods of 9 months and 12 months, respectively.

As of December 31, 2022, there were approximately 14.0 shares of common stock available for future grants under the 2017 Incentive Plan.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. Expected volatility assumptions used in the binomial lattice model are based on an analysis of implied volatility of publicly traded options on our stock and historical volatility of our stock price. The risk-free interest rate is derived from the U.S. Treasury strip rates at the time of the grant. The expected term of the options was derived from the outputs of the binomial lattice model, which incorporates post-vesting forfeiture assumptions based on an analysis of historical data. The dividend yield was based on our estimate of future dividend yields. Similar groups of employees that have dissimilar exercise behavior are considered separately for valuation purposes. We utilize the multiple-grant approach for recognizing compensation expense associated with each separately vesting portion of the share-based award.

The following weighted-average assumptions were used to estimate the fair values of options granted during the years ended December 31, 2022, 2021 and 2020:

	2022	2021	2020
Risk-free interest rate	1.97 %	1.44 %	1.30 %
Volatility factor	29.00 %	30.00 %	26.00 %
Dividend yield (annual)	1.10 %	1.50 %	1.40 %
Weighted-average expected life (years)	5.10	5.50	4.30

The following weighted-average fair values were determined for the years ending December 31, 2022, 2021 and 2020:

	2022	2021	2020
Options granted during the year	$ 116.92	$ 79.91	$ 54.05
Restricted stock awards granted during the year	453.70	317.70	272.37

The binomial lattice option-pricing model requires the input of subjective assumptions including the expected stock price volatility. Because our stock option grants have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in our opinion, existing models do not necessarily provide a reliable single measure of the fair value of our stock option grants.

Employee Stock Purchase Plan

We have registered 14.0 shares of common stock for the Employee Stock Purchase Plan (the "Stock Purchase Plan"), which is intended to provide a means to encourage and assist employees in acquiring a stock ownership interest in Elevance Health. Pursuant to the terms of the Stock Purchase Plan, an eligible employee is permitted to purchase no more than $25,000 (actual dollars) worth of stock in any calendar year, based on the fair value of the stock at the end of each plan quarter. Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Once purchased, the stock is accumulated in the employee's investment account. The Stock Purchase Plan allows participants to purchase shares of our common stock at a discounted price per share of 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter purchase period. The Stock Purchase Plan discount was recognized as compensation expense for the year ended December 31, 2022, based on GAAP guidance. During the years ended December 31, 2022, 2021 and 2020, we issued 0.1, 0.1 and 0.2 shares, respectively, under the Stock Purchase Plan, and we received cash of $62, $55 and $47, respectively, for such shares. As of December 31, 2022, 4.3 shares were available for issuance under the Stock Purchase Plan.

Use of Capital and Stock Repurchase Program

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

A summary of the cash dividend activity for the years ended December 31, 2022 and 2021 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Year ended December 31, 2022				
January 25, 2022	March 10, 2022	March 25, 2022	$ 1.28	$ 309
April 19, 2022	June 10, 2022	June 24, 2022	1.28	309
July 19, 2022	September 9, 2022	September 23, 2022	1.28	306
October 18, 2022	December 5, 2022	December 21, 2022	1.28	305
Year ended December 31, 2021				
January 26, 2021	March 10, 2021	March 25, 2021	$ 1.13	$ 277
April 20, 2021	June 10, 2021	June 25, 2021	1.13	278
July 20, 2021	September 10, 2021	September 24, 2021	1.13	276
October 19, 2021	December 3, 2021	December 21, 2021	1.13	273

On January 24, 2023, our Audit Committee declared a quarterly cash dividend to shareholders of $1.48 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 24, 2023 to the shareholders of record as of March 10, 2023.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On January 26, 2021, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized a $5,000 increase to our common stock repurchase program. On January 24, 2023, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized a $5,000 increase to our common stock repurchase program. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time. We intend to utilize this authorization over a multi-year period, subject to market and industry conditions. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are affected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary, as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

A summary of common stock repurchases for the years ended December 31, 2022 and 2021 is as follows:

	Years Ended December 31	
	2022	2021
Shares repurchased	4.8	5.1
Average price per share	$ 478.99	$ 371.46
Aggregate cost	$ 2,316	$ 1,900
Authorization remaining at end of year	$ 1,876	$ 4,192

We expect to utilize the remaining authorized amount over a multi-year period, subject to market and industry conditions.

For additional information regarding the use of capital for debt security repurchases, see Note 13, "Debt."

16. Accumulated Other Comprehensive (Loss) Income

A reconciliation of the components of accumulated other comprehensive (loss) income at December 31, 2022, 2021, and 2020 is as follows:

	2022	2021	2020
Net unrealized investment gains:			
Beginning of year balance	$ 492	$ 949	$ 521
Other comprehensive (loss) income before reclassifications, net of tax benefit (expense) of $926, $121, and $(160), respectively	(2,614)	(357)	478
Amounts reclassified from accumulated other comprehensive income, net of tax benefit (expense) of $(94), $27, and $(13), respectively	354	(100)	(50)
Other comprehensive (loss) income	(2,260)	(457)	428
End of year balance	(1,768)	492	949
Non-credit components of impairments on investments:			
Beginning of year balance	—	(2)	(2)
Other comprehensive income, net of tax (expense) benefit of $0, $(1),and $0, respectively	(3)	2	—
End of year balance	(3)	—	(2)
Net cash flow hedges:			
Beginning of year balance	(239)	(250)	(262)
Other comprehensive income, net of tax expense of $(6), $(3), and $(3), respectively	10	11	12
End of year balance	(229)	(239)	(250)
Pension and other postretirement benefits:			
Beginning of year balance	(429)	(552)	(551)
Other comprehensive income (loss), net of tax expense of $(23), $(36), and $(2), respectively	(70)	123	(1)
End of year balance	(499)	(429)	(552)
Future policy benefits			
Beginning of year balance	(19)	—	—
Adoption of ASU 2018-12	—	(12)	—
Other comprehensive income (loss), net of tax (expense) benefit of (10), $2, and $0, respectively	32	(7)	—
End of year balance	13	(19)	—
Foreign currency translation adjustments:			
Beginning of year balance	(4)	5	(2)
Other comprehensive (loss) income, net of tax benefit (expense) of $6, $2, and $(2)	(13)	(9)	7
End of year balance	(17)	(4)	5
Total:			
Total beginning of year accumulated other comprehensive (loss) income	(197)	150	(296)
Adoption of ASU 2018-12	—	(12)	—
Total other comprehensive (loss) income, net of tax benefit (expense) of $799, $112, and $(154), respectively	(2,304)	(337)	446
Total other comprehensive loss attributable to noncontrolling interests, net of tax (expense) benefit of $(3), $1, and $0, respectively	11	2	—
Total end of year accumulated other comprehensive (loss) income	$ (2,490)	$ (197)	$ 150

17. Reinsurance

We reinsure certain risks with other companies and assume risk from other companies. We remain primarily liable to policyholders under ceded insurance contracts and are contingently liable for amounts recoverable from reinsurers in the event that such reinsurers do not meet their contractual obligations.

A summary of direct, assumed and ceded premiums earned for the years ended December 31, 2022, 2021 and 2020 is as follows:

	2022	2021	2020
Direct	$ 128,867	$ 113,149	$ 100,832
Assumed	4,426	4,298	3,356
Ceded	(64)	(74)	(79)
Net premiums	$ 133,229	$ 117,373	$ 104,109
Percentage—assumed to net premiums	3.3%	3.7%	3.2%

The difference between written premiums and earned premiums is immaterial in each of the years presented above.

A summary of net premiums earned by segment (see Note 20, "Segment Information") for the years ended December 31, 2022, 2021 and 2020 is as follows:

	2022	2021	2020
Reportable segments:			
Health Benefits	$ 131,964	$ 115,725	$ 102,643
Carelon Services	1,265	1,648	1,466
Net premiums	$ 133,229	$ 117,373	$ 104,109

The effect of reinsurance on benefit expense for the years ended December 31, 2022, 2021 and 2020 is as follows:

	2022	2021	2020
Direct	$ 112,964	$ 98,933	$ 85,168
Assumed	3,730	3,719	2,967
Ceded	(52)	(81)	(90)
Net benefit expense	$ 116,642	$ 102,571	$ 88,045

18. Leases

We lease office space and certain computer and related equipment using noncancelable operating leases. Our leases have remaining lease terms of 1 year to 12 years.

The information related to our leases is as follows:

	Balance Sheet Location	December 31, 2022	December 31, 2021
Operating Leases			
ROU assets	Other noncurrent assets	$ 604	$ 628
Lease liabilities, current	Other current liabilities	181	133
Lease liabilities, noncurrent	Other noncurrent liabilities	751	864

	Years Ended December 31		
	2022	2021	2020
Lease Expense			
Operating lease expense	$ 143	$ 261	$ 438
Short-term and variable lease expense	35	45	50
Sublease income	(3)	(4)	(9)
Total lease expense	$ 175	$ 302	$ 479

Our activities as disclosed in Note 4, "Business Optimization Initiatives," include reducing our office space footprint. As a result, we performed an interim impairment test during the years ended December 31, 2022, 2021 and 2020, and recorded impairment charges of $34, $136 and $258, respectively, for impairment and abandonment of ROU assets which are included in the operating lease expense shown above.

	Years Ended December 31	
	2022	2021
Other information		
Operating cash paid for amounts included in the measurement of lease liabilities, operating leases	$ 204	$ 198
ROU assets obtained in exchange for new lease liabilities, operating leases	$ 113	$ 334
Weighted average remaining lease term in years, operating leases	7	7
Weighted average discount rate, operating leases	2.98 %	2.69 %

At December 31, 2022, future lease payments for noncancelable operating leases with initial or remaining terms of one year or more are as follows:

2023	$ 206
2024	179
2025	145
2026	111
2027	77
Thereafter	310
Total future minimum payments	1,028
Less imputed interest	(96)
Total lease liabilities	$ 932

19. Earnings per Share

The denominator for basic and diluted earnings per share at December 31, 2022, 2021 and 2020 is as follows:

	2022	2021	2020
Denominator for basic earnings per share—weighted-average shares	240.0	243.8	250.8
Effect of dilutive securities—employee stock options, non-vested restricted stock awards, convertible debentures and equity units	2.8	3.0	3.5
Denominator for diluted earnings per share	242.8	246.8	254.3

During the years ended December 31, 2022, 2021 and 2020, weighted-average shares related to certain stock options of 0.4, 0.2 and 1.2, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive.

During the years ended December 31, 2022, 2021 and 2020, we issued approximately 0.2, 0.3 and 0.3 restricted stock units, respectively, of which vesting was contingent upon us meeting certain earnings targets. Contingent restricted stock units are excluded from the denominator for diluted earnings per share and are included only if and when the contingency is met. The 2022 contingent restricted stock units are being measured over the three year period of 2022 through 2024, the 2021 contingent restricted stock units are being measured over the three year period of 2021 through 2023 and the 2020 contingent restricted stock units are being measured over the three year period of 2020 through 2022. Contingent restricted stock units generally vest in March of the year following each measurement period.

20. Segment Information

As discussed in Note 1 "Organization", we are reorganizing our brand portfolio into three core go-to-market brands over the next several years. 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. As a result, we changed our reportable segments to the following beginning in the first quarter of 2023: 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).

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 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 services such as formulary management, pharmacy networks, specialty and home delivery pharmacy services and member services.

Our Carelon Services segment is focused on lowering the cost and improving the quality of healthcare by enabling and creating new care delivery and payment models, with a special emphasis on serving those with complex and chronic conditions. Carelon Services offers a broad array of healthcare-related services and capabilities to internal and external customers including integrated care delivery, behavioral health, palliative care, utilization management, payment integrity services and subrogation services, as well as health and wellness programs.

Our Corporate and 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.

We define operating revenues to include premium income, product revenue and service fees. Operating revenues are derived from premiums and fees received, primarily from the sale and administration of health benefits and pharmacy products and services. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and operating expense.

Affiliated revenues represent revenues or costs for services provided to our subsidiaries by CarelonRx and Carelon Services, in addition to certain back-office services provided by our international businesses, which are recorded at cost or management's estimate of fair market value. These affiliated revenues are eliminated in consolidation. For segment reporting, we present all capitation risk arrangements on a gross basis; therefore, eliminations also include adjustments for capitated risk arrangements that are recognized on a net basis under GAAP.

Through our participation in various federal government programs, we generated approximately 28% of our total consolidated revenues from agencies of the U.S. government for each of the years ended December 31, 2022, 2021, and 2020. The majority of these revenues are contained in our Health Benefits segment. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S. and Puerto Rico.

The accounting policies of the segments are consistent with those described in the summary of significant accounting policies in Note 2, "Basis of Presentation and Significant Accounting Policies," except that all capitation risk arrangements are reported on a gross basis with an adjustment included in eliminations for capitated risk arrangements that are presented on a net basis under GAAP. We evaluate performance of the reportable segments based on operating gain or loss as defined above. We evaluate net investment income, net gains (losses) on financial instruments, interest expense, amortization expense, gain or loss on extinguishment of debt, income taxes and assets and liabilities on a consolidated basis, as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

Financial data by reportable segment for the years ended December 31, 2022, 2021 and 2020 is as follows:

		Carelon					
	Health Benefits	CarelonRx	Carelon Services	Total	Corporate & Other	Eliminations	Total
Year Ended December 31, 2022							
Premiums	$ 131,964	$ —	$ 1,499	$ 1,499	$ —	$ (234)	$ 133,229
Product revenue	—	14,978	—	14,978	—	—	14,978
Service fees	6,520	—	882	882	51	—	7,453
Operating revenue - unaffiliated	138,484	14,978	2,381	17,359	51	(234)	155,660
Operating revenue - affiliated	—	13,548	9,896	23,444	966	(24,410)	—
Operating revenue - total	$ 138,484	$ 28,526	$ 12,277	$ 40,803	$ 1,017	$ (24,644)	$ 155,660
Operating gain (loss)	$ 6,061	$ 1,868	$ 455	$ 2,323	$ (101)	$ —	$ 8,283
Year Ended December 31, 2021							
Premiums	$ 115,725	$ —	$ 1,786	$ 1,786	$ —	$ (138)	$ 117,373
Product revenue	—	12,657	—	12,657	—	—	12,657
Service fees	6,003	—	842	842	68	—	6,913
Operating revenue - unaffiliated	121,728	12,657	2,628	15,285	68	(138)	136,943
Operating revenue - affiliated	—	12,774	7,020	19,794	534	(20,328)	—
Operating revenue - total	$ 121,728	$ 25,431	$ 9,648	$ 35,079	$ 602	$ (20,466)	$ 136,943
Operating gain (loss)	$ 5,884	$ 1,684	$ 118	$ 1,802	$ (127)	$ —	$ 7,559
Year Ended December 31, 2020							
Premiums	$ 102,643	$ —	$ 1,466	$ 1,466	$ —	$ —	$ 104,109
Product revenue	—	10,384	—	10,384	—	—	10,384
Service fees	5,628	—	643	643	44	—	6,315
Operating revenue - unaffiliated	108,271	10,384	2,109	12,493	44	—	120,808
Operating revenue - affiliated	—	11,527	3,611	15,138	293	(15,431)	—
Operating revenue - total	$ 108,271	$ 21,911	$ 5,720	$ 27,631	$ 337	$ (15,431)	$ 120,808
Operating gain (loss)	$ 5,125	$ 1,361	$ 28	$ 1,389	$ (154)	$ —	$ 6,360

Asset, liability and equity details by reportable segment have not been disclosed, as we do not internally report such information.

A reconciliation of reportable segments' operating revenue to the amounts of total revenues included in our consolidated statements of income for the years ended December 31, 2022, 2021 and 2020 is as follows:

	2022	2021	2020
Reportable segments' operating revenues	$ 155,660	$ 136,943	$ 120,808
Net investment income	1,485	1,378	877
Net (losses) gains on financial instruments	(550)	318	182
Total revenues	$ 156,595	$ 138,639	$ 121,867

A reconciliation of reportable segments' operating gain to income before income tax expense included in our consolidated statements of income for the years ended December 31, 2022, 2021 and 2020 is as follows:

	2022	2021	2020
Income before income tax expense	$ 7,600	$ 7,995	$ 6,238
Net investment income	(1,485)	(1,378)	(877)
Net losses (gains) on financial instruments	550	(318)	(182)
Interest expense	851	798	784
Amortization of other intangible assets	767	441	361
Loss on extinguishment of debt	—	21	36
Reportable segments' operating gain	$ 8,283	$ 7,559	$ 6,360

21. Related Party Transactions

We have an equity investment in APC Passe, LLC, which offers Medicaid products in Arkansas. During the years ended December 31, 2022, 2021 and 2020, in the normal course of business, we assumed premiums of $501, $462 and $446, respectively, from APC Passe, LLC, which is included in our total assumed premiums (see Note 17, "Reinsurance").

22. Statutory Information

The majority of our insurance and HMO subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, commonly referred to as statutory accounting, which vary in certain respects from GAAP. However, certain of our insurance and HMO subsidiaries, including BCC, Blue Cross of California Partnership Plan, Inc., Golden West Health Plan, Inc., Beacon Health Options of California, Inc. and CareMore Health Plan are regulated by the California Department of Managed Health Care ("DMHC") and report their accounts in conformity with GAAP (these entities are collectively referred to as the "DMHC regulated entities"). Typical differences of GAAP reporting as compared to statutory reporting are the recognition of all assets including those that are non-admitted for statutory purposes and recognition of all deferred tax assets without regard to statutory limits. The National Association of Insurance Commissioners ("NAIC") developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting. Prescribed statutory accounting practices are set forth in a variety of publications of the NAIC as well as state laws, regulations and general administrative rules.

Our statutory basis insurance and HMO subsidiaries are subject to risk-based capital ("RBC") requirements. RBC is a method developed by the NAIC to determine the minimum amount of statutory capital appropriate for an insurance company or HMO to support its overall business operations in consideration of its size and risk profile. The formula for determining the amount of RBC specifies various factors, weighted based on the perceived degree of risk, which are applied to certain financial balances and financial activity. Below minimum RBC requirements are classified within certain levels, each of which requires specified corrective action. Additionally, the DMHC regulated entities are subject to capital and solvency requirements as prescribed by the DMHC. As of December 31, 2022 and 2021, all of our regulated subsidiaries exceeded the minimum applicable mandatory RBC requirements and/or capital and solvency requirements of their applicable governmental regulator.

The statutory RBC necessary to satisfy regulatory requirements of our statutory basis insurance and HMO subsidiaries was approximately $7,900 and $6,962 as of December 31, 2022 and 2021, respectively. The tangible net equity required for the DMHC regulated entities was approximately $710 and $690 as of December 31, 2022 and 2021, respectively. Statutory-basis capital and surplus of our insurance and HMO subsidiaries and capital and surplus of our other regulated subsidiaries, excluding the DMHC regulated entities, was $19,048 and $16,178 at December 31, 2022 and 2021, respectively. GAAP equity of the DMHC regulated entities was $3,795 and $3,886 at December 31, 2022 and 2021, respectively.

Our ability to pay dividends and credit obligations is significantly dependent on receipt of dividends from our subsidiaries. The payment of dividends to us by our insurance and HMO subsidiaries without prior approval of the insurance departments of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective state insurance departments or the DMHC. During 2022, our insurance and HMO subsidiaries paid aggregate cash dividends of $3,097 to the parent company, including cash dividends which required prior approval from regulatory authorities. We currently estimate that approximately $3,500 of dividends will be paid to the parent company in 2023.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(c) Financial Statement Schedule

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

Schedule II—Condensed Financial Information of Registrant

Elevance Health, Inc. (Parent Company Only)
Balance Sheets

(In millions, except share data)	December 31, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 942	$ 630
Fixed maturity securities (amortized cost of $175 and $512; allowance for credit losses of $0 and $1)	163	515
Equity securities	104	49
Other receivables	55	40
Net due from subsidiaries	—	446
Other current assets	721	655
Total current assets	1,985	2,335
Other invested assets	783	808
Property and equipment, net	187	207
Deferred tax assets, net	313	77
Investments in subsidiaries	58,978	56,410
Other noncurrent assets	240	265
Total assets	$ 62,486	$ 60,102
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	$ 894	$ 559
Net due to subsidiaries	789	—
Current portion of long-term debt	1,500	1,599
Other current liabilities	361	344
Total current liabilities	3,544	2,502
Long-term debt, less current portion	22,324	21,132
Other noncurrent liabilities	375	373
Total liabilities	26,243	24,007
Commitments and contingencies—Note 5		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 237,958,067 and 241,770,746	2	2
Additional paid-in capital	9,084	9,148
Retained earnings	29,647	27,142
Accumulated other comprehensive loss	(2,490)	(197)
Total shareholders' equity	36,243	36,095
Total liabilities and shareholders' equity	$ 62,486	$ 60,102

See accompanying notes.

Elevance Health, Inc. (Parent Company Only)
Statements of Income

(In millions)	Years ended December 31 2022	2021	2020
Revenues			
Net investment income	$ 4	$ 6	$ 65
Net gains on financial instruments	2	6	28
Service fees	7	24	22
Total revenues	13	36	115
Expenses			
Operating expense	188	119	169
Interest expense	845	794	779
Loss on extinguishment of debt	—	21	36
Total expenses	1,033	934	984
Loss before income tax credits and equity in net income of subsidiaries	(1,020)	(898)	(869)
Income tax credits	(461)	(244)	(386)
Equity in net income of subsidiaries	6,453	6,812	5,055
Shareholders' net income	$ 5,894	$ 6,158	$ 4,572

See accompanying notes.

Elevance Health, Inc. (Parent Company Only)
Statements of Comprehensive Income

(in millions)	Years ended December 31		
	2022	**2021**	**2020**
Shareholders' net income	$ 5,894	$ 6,158	$ 4,572
Other comprehensive (loss) income, net of tax:			
Change in net unrealized gains/losses on investments	(2,249)	(455)	428
Change in non-credit component of impairment losses on investments	(3)	2	—
Change in net unrealized gains/losses on cash flow hedges	10	11	12
Change in net periodic pension and postretirement costs	(70)	123	(1)
Change in future policy benefits	32	(7)	—
Foreign currency translation adjustments	(13)	(9)	7
Other comprehensive (loss) income	(2,293)	(335)	446
Total shareholders' comprehensive income	$ 3,601	$ 5,823	$ 5,018

See accompanying notes.

Elevance Health, Inc. (Parent Company Only)
Statements of Cash Flows

(In millions)	Years ended December 31		
	2022	**2021**	**2020**
Net cash provided by operating activities	$ 1,447	$ 2,038	$ 4,810
Investing activities			
Purchases of investments	(367)	(2,059)	(2,729)
Proceeds from sales, maturities, calls and redemptions of investments	618	2,449	2,593
Repayment (issuance) of note to subsidiary	1,500	(1,500)	—
Capitalization of subsidiaries	(411)	(807)	(2,460)
Changes in securities lending collateral	36	173	(234)
Purchases of property and equipment, net of sales	(47)	(77)	(107)
Other, net	—	—	11
Net cash provided by (used in) investing activities	1,329	(1,821)	(2,926)
Financing activities			
Net (repayments of) proceeds from commercial paper borrowings	(300)	50	(150)
Proceeds from long-term borrowings	3,071	3,462	2,484
Repayments of long-term borrowings	(1,899)	(1,068)	(1,932)
Changes in securities lending payable	(36)	(173)	234
Repurchase and retirement of common stock	(2,316)	(1,900)	(2,700)
Cash dividends	(1,290)	(1,158)	(1,000)
Proceeds from issuance of common stock under employee stock plans	182	203	176
Taxes paid through withholding of common stock under employee stock plans	(93)	(102)	(128)
Other, net	217	399	14
Net cash used in financing activities	(2,464)	(287)	(3,002)
Change in cash and cash equivalents	312	(70)	(1,118)
Cash and cash equivalents at beginning of year	630	700	1,818
Cash and cash equivalents at end of year	$ 942	$ 630	$ 700

See accompanying notes.

Elevance Health, Inc.
(Parent Company Only)
Notes to Condensed Financial Statements

December 31, 2022
(In Millions, Except Per Share Data)

1. Basis of Presentation and Significant Accounting Policies

In the parent company only financial statements of Elevance Health, Inc. ("Elevance Health"), Elevance Health's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Elevance Health's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Elevance Health.

Elevance Health's parent company only financial statements should be read in conjunction with Elevance Health's audited consolidated financial statements and the accompanying notes included in Part II, Item 8 of this Exhibit 99.1.

2. Subsidiary Transactions

Dividends from Subsidiaries

Elevance Health received cash dividends from subsidiaries of $3,097, $3,134 and $3,618 during 2022, 2021 and 2020, respectively.

Dividends to Subsidiaries

Certain subsidiaries of Elevance Health own shares of Elevance Health common stock. Elevance Health paid cash dividends to subsidiaries related to these shares of common stock in the amount of $61, $54 and $46 during 2022, 2021 and 2020, respectively.

Investments in Subsidiaries

Capital contributions to subsidiaries were $411, $3,271 and $2,460 during 2022, 2021 and 2020, respectively.

Amounts Due From and To Subsidiaries

At December 31, 2022 and 2021, Elevance Health reported amounts due (to) from subsidiaries of $(789) and $446, respectively. The amounts due (to) and from subsidiaries primarily include amounts for allocated operating expenses or daily cash management activities. These items are routinely settled, and as such, are classified as current liabilities or assets.

In June 2021 Elevance Health entered into a short-term loan agreement with a subsidiary for the amount of $1,500, which is also included in amounts due from subsidiaries at December 31, 2021. This loan was repaid in February 2022.

Guarantees on Behalf of Subsidiaries

Elevance Health guarantees contractual or financial obligations or solvency requirements for certain of its subsidiaries. These guarantees approximated $550 at December 31, 2022. There were no payments made on these guarantees in 2022.

3. Derivative Financial Instruments

The information regarding derivative financial instruments contained in Note 6, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements of Elevance Health and its subsidiaries, included in Part II, Item 8 of this Exhibit 99.1, is incorporated herein by reference.

4. Long-Term Debt

The information regarding long-term debt contained in Note 13, "Debt," of the Notes to Consolidated Financial Statements of Elevance Health and its subsidiaries, included in Part II, Item 8 of this Exhibit 99.1, is incorporated herein by reference.

5. Commitments and Contingencies

The information regarding commitments and contingencies contained in Note 14, "Commitments and Contingencies," of the Notes to Consolidated Financial Statements of Elevance Health and its subsidiaries, included in Part II, Item 8 of this Exhibit 99.1, is incorporated herein by reference.

6. Capital Stock

The information regarding capital stock contained in Note 15, "Capital Stock," of the Notes to Consolidated Financial Statements of Elevance Health and its subsidiaries, included in Part II, Item 8 of this Exhibit 99.1, is incorporated herein by reference.